William Franklin Tanner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar Reg No.										0 1900	
Physicia	n/	Decedent's Name (First, Middi	e,Last)				-		2	Date of Dear	th Day Yea		3. Time of Death
ledical Examin		William_	Franklin		Tann					June 2, 20	006		0701 hrs
>		4a Facility Name (if not institution St. Mary's Hospital EF	_	umber)			. City, Town, or L Leonard City			wn	4c. County of St. Mary		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In	yrs last birth	nday)	If Under 1 Year Months Days		24Hrs. Min.		th(MM/DD/YYYY	Foreign	n
Director		217-04-4789	1X M 2 F	2	8	Yrs.				09/11	./1977	Cor	intry)Maryland
ž.	ŀ	Usual Residence of Decedent 10a. State 10b. County		100	City, Town	or Locatio	n						10d Inside City Limits
ow any				100.	Oity, TOWIT	or Locatio							1 Yes 2 X No
yland -f sh	٥	Maryland St. 10e. Street and Number	Mary's				Lexingte	on Pa	ırk	L	0 0:::		
mar r 28s	Director						·			1	0g. Citizen of Wh	iai Couri	uy?
ith the Maryland 23a or 28a-f show s	밁	22233 Scott 11. Marital Status	Circle 12. Was De	andont Ever	in III Ċ	12 W==	Decedent of Hisp	0653	-0 / 0	.f. V N.	United		ates can Indian, Black,
ath w items	Funeral		arried Armed F	orces?			s, specify Cuban,				White		an indian, black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene nut: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		3 Widowed 4 Div	1 Yes orced If Yes, Give Ye	2 X I	Vo	1 \	res 2 X No	specify:			Specify:	Whi	.te
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	홝	15. Decedent's Education (Spe	or Dates:			Decedent's	s Usual Occupation	on (Give k			16b. Kind of Bu		
72 ho	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	— (during mos	st of working life	DO NOT L	use retired	d)			
215-0036 be filed within 77 ntal Hygiene rked other than ent, the Medical	립	11					Electri	cian			E:	lect	rical
5-0 lled w Hygid	ပ၂	17. Father's Name (First, Middle,	Last)				1	8.Mother's	Name (F	irst, Middle, I	Maiden Surname))	
121 d be f lental arked	B	William Fran		ner, S		A # 101					aine Sou		
ID 21215-003 should be filed withi and Mental Hygiene 7 is marked other In natic event, the Med	의		1 ()1 /	- /24 - + 1		_	,				nber, City or Towi	, - ,	, ,
e, MD 2121: I and 2 should be fil Health and Montal I Item 27 is marked item 27 is marked	-	Becky Lorrai 20a. Method of Disposition	ne Tannei				on (Name of cerr			xingto Date	n Park,	City or	ZU653 Town, State
nore, MD 2121 signs 1 and 2 should be find Of Health and Mental t: If item 27 is marked other traumatic event,		1 Burial 2 X Cremation	3 Removal f			ory or othe		,,				,	
	4	4 Donation 5 Other Si 21. Signature of Funeral Service			Brins		I-Echols me and Address						Hall, MD
Balti permit Departir Importi		Kyle S. Simo		M012	06				DII				ome, P.A. D 20650-027
Physician		23a Part I Enter the disease, or	complications that										Approximate Interval
/Medical	-	failure. List only one cause Immediate Cause (Final disease	Mothode	one into	oxicati	on							Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as										
		Sequentially list conditions,	b										
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequer	nce of):								
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):								
		Xpsupsp	d. X AMENDED	item	#/ib 23a	27 28	Ba-f,perME	c857	7/29/	<u> </u>			
e be e ysicial	n/Medical	X UNPENDED				921 920	zi i,perin	, goor ,	1/20/		Toolog		
8760, tificate be ng physic as the burn	2 ≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of birth		Feta	al death 3	Ectopic	pregnanc	су	23d. Date of Month		ay Year
Box 687 e death certific the attending p ed for use as th	siclar		known	nant at time	of death	Oth	er (Specify)						
that the des	3		9 Onki			- 1- 41		i a Da	4.1	220 Did+	abassa usa santri	huta ta i	the cause of death?
rices that the signed by	à	Part II. Other significant condi	ions continuating	to death but	notresulting	g in the ur	idenying cadse gi	iven in Fai	£ F.				ably 4 Unknown
ords, we requires is been signatured be	ted									24a. Was			topsy findings available
COTC law re has be 2 sho	흴									autop	osy p		ompletion of cause of
Rec The The incate	Completed									1 Yes		✓ Ye	s 2 No
1) / Ll ing Physician: The law require the Physician: The law require the physician: The law require the physician page 2 should bureral director, page 2 should bureral director, page 2 should bureral director.	Be	25 Was case referred to medica examiner?	Hospital:	Inpatient	2 - ED/O	utpatient		of Death (Residence 6	Other	Casas
1 of V Ing Phys	٤	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury		Time of In		y at Work?			how injury occurr		Scerie
Te full and a second	ioi	1 National		th, Day,Year) 0/2/2006	.	6:00		es 2 χ	No	unk			
Division as or Attendin s after death as Director: A led in by the fu	ertification:	. V	stigation			-	, factory, office bu	21		8f. Location (ral Route Number, City
Division pital or Attene ours after death eral Director: filled in by the	erti	Juicide ood	ermined (Special	lotel					b.	or Town, S eonardt d	State) Days] own MD	Lnn R	m 316
	alC	(Orlow Orly	hysician: To the be	est of my kno	wledge, dea	ath occurr	ed at the time, da	te and pla				as start	ed
To the How within 24 h To the Fur	Medica	2 🖳	iminer: On the basis and manner		tion and/or i	nvestigati			curred at 1	he time, date			
_	Σ	29b. Signature and title of certifi	er .				29c License				29d. Date sign	,	ith, Day, Year)
		Mayoute VI	re youll				O.C.N	vi. C.			June 3, 200		
		 Name and address of person Margarita Korell MD. 	n who completed ca Assistant Me			111 Pa	nn Street, Ba	altimore	MD 2	1201			
St	ate			Registrar's S		,,,,,	511661, 156		, 2	• ·	-		
Regist		31. Date filed (Month, Day Year)	2006	2000	K A	head	3						
DHMH 17 Rev 1/20	001				OR	RIGINAL							

1 - State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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/Med		CAROLYN	If not institution, give	R			VINSON 4b. City, Town, o		Mar		ounty of Death	0 11:15 AM
Exam	iner		1			-1-	40. City, Town, 0		eatii -		U'ICOS	
tes.		5. Social Security N		ab a Nur	(In yrs. teet bi	rthday)	If Under 1 Year	If Under 24		lirth		
Funerà Directo	_	215-18-4 Usual Residence of	705	□M 2(X F	83	Yrs.	Months Days	Hours N	Ain. (Month, C	Day, Year) 14,192	23 MAR	nplace (State or Foreign untry) YLAND
land		10a. State	10b. County		10c. City, Tow	m or Lo	cation					10d. Inside City Limits
Mary -f sh	P	MD	WICOMI	CO	M	ARDF	LA SPRIN	GS				1∰Yes 2□No
r 28a	Director	10e. Street and Nu					10f. Zip Code			10g. Citize	en of What Cou	untry?
h witi	O E	305 BRAT	TEN STREE	Т			218	37		τ	JSA	
dea	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H	dispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	No- 14	4. Race - Amer Black, White	
ilied within 72 hours after death with the Maryland Hygiene. Hygiene. The than "nature!, or items 23e or 28e-f show on, the Modical Expoduent countried at	by Fu	1 ☐ Never Man 3 → Widowed	ried 2 Married	1 ∐ Yes 2 📉 N If Yes, Give	lo		I□Yes 2⊠No					
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n 72	lete		15. Decedent's Ed cify only highest grad	de completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of d)	working	16b. Kind	d of Business/l	industry
ie, ividi yldild ZIZIO- s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, Ing Madical	Completed	Elementary/Second 1.2	ondary (0-12)	College (1-4or 5	+)		MEMAKER	,		(OWN HOM	Œ
e files Hygothe	BeC	17. Father's Name	(First, Middle, Last)					18. Mother's	Name (First, Midd	le, Maiden S	Sumame)	
al yidilid Kila should be filed with nd Mental Hygiene, marked other than	To E	CARLTON		EDWARD	R	OBER	RTSON	MATT	E		Н	IUGHES
and h	Ι΄	19a. Informant's N	ame/Relationship (7	ype, Print)	198	o. Mailin	g Address (Street	and Number o	r Rural Route Num	ber, City or 1	Town, State, Z	lip Code)
and and m 27			EAR- DAUGH	TER			CITADEL	DRIVE	SEVERN,			
Pages 1 Pages 1 Int: if ite		20a. Method of Dis	position Cremation 3	Removal from State	20b. Place o	of Dispo: ory, crem	sition (Name of natory or other pla	сө)	Date	20c. Loca	ation - City or 1	Town, State
Pag tment tant:		4 Donation	5 Other (Specify)	MARDEI	A M	EMORIAL	CEM 6/				RINGS, MD
Deficiency 19 permit. Pages 1 and Department of Health Important: if them 27 eny injury or other trees.	i	21. Signature of F	uneral Service Licen	see cal	60		. Name and Addre		BOUNDS F			
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		shock, or hea		blications that caused the cause on each lin	18.	not ente	er trie mode or dyli	ng, such as car	diac or respiratory	arrest,		Interval Between Onset and Death
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Examine				Due to (or as	a consequence	of):	2 6		0,00			4
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cuted id ansit	Examiner	Cause (Disease of that initiated event	eriying r injury s	Ays	0-4	رم					1,	60001-
e exectant and arrial-tr		resulting in death)	Last	Due to (or as	a consequence	of):	1.00					
th certificate be executed the certificate be executed tending physician and ruse as the burial-transit	an/Medical		•	d								
A O sertific ding p	Me	IF FEMALE:		23c. If yes, outcome	of occapancy							
eath cer attendir for use	clan	23b. Was deceder in the past 12	2 months?	1 Live birth 4 Pregnant at	2 Fetal death		Ectopic pregnanc Other (specify)	у		23	3d. Date of deli- Month	very Day Year
the d	Physic	1 Yes 2 9 Unknowr		9□ Unknown	anno or dodar	0_	g durier (specify)					
s that	by Pt	Part II. Other signi	ficant conditions co	ontributing to death b	ut not resulting	in the ur	nderlying cause giv	ven in Part I.	23e. Dio	tobacco use	e contribute to	the cause of death?
requires requires rould be									_ 10	Yes 2 🗗	HNo 3□Pro	obably 4 Unknown
aw re	plet								24a. We	as an	24b. Were au	topsy findings available completion of cause of
The The ste ha	Completed								— aud per 1 ☐ Yes	Tormed?	death?	
Jien:	Be	25. Was case refe examiner?	rred to medical					26. Place of	Death (Check only			
Physic this co	ု	1 Yes 2			nt 2□ER/O		t 3LI DUA		ng Home 5 ☐ Re	sidence 6	Other (Spec	cify)
ding P	, LO	27. Manner of Dea 1 A Natural	5 Pending	28a. Date of Inju (Month, Da	ry y Year) 28b.	Time of Injury	Wo		28d. Describ	e how injury	occurred	
death death tor:	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be					Yes 2 □ No	004 (/C+	M	10-11
tal or A rs after ai Direct ed in by	Certification:	4 Homicide	determined	building, et	c. (Specify)	arm, str	eet, factory, office			own, State)	Number of Au	ıral Route Number,
To the Hospital or Attending Physicien: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for	edical	29a. Certifier (Check only one)	1 Deertifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examination a	e, death nd/or inv	occurred at the ti vestigation, in my o	me, date and popinion, death o	lace, and due to the	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
To the To the Comp	Z	29b. Signature and	title of certified	n			29c. Licens	se number		29d. Date	signed (Month	h, Dey, Year)
112	8		///////	Tus			0	283	49	81	730/1	8
1,0		30. Name and add	ress of person who	completed cause of d	eath (Item 23a)	(Туре,	Print)	_		. /.	1	
V		Willio	m H.	Kobins	W.D.	_2	.00 Civ	vic Au	e Sal	isbu	ry M	1081804
Regis	tate trar	31. Date filed (Moi		32. Hagistr	ar's Signature	1	and -					
DHMH 17 Rev 1	10.		0011 0 1 2	.000	18.1 J.S.	A						

		•	For State State Registrer		artment of Health and rtificate of Death	Mental Hygie	2000	19003		
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death		
	Physici /Medic		Ralph De Witt Walke	r			Day Year 2006	3:00 A.M		
	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Dea	i	4c. County of Deal			
			3927 Level Road		Havre de Grace		Harfor			
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday) 85 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Feb. 18,	oth 9. Birthplace (State or Foreign Country) 18, 1921 Maryland			
	Director		Usual Residence of Decedent	05		reb. 10,	1 22 IFAL	/ Land		
	show		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits		
	Ba-1 s	ctor	MD Harford	Havre o	de Grace			1 ☐ Yes 2 ☑ No		
	with th	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Co	ountry?		
	s 23s	Fra	3927 Level Road	ecedent Ever in U.S. 13.	21078	Specify Ves or No.	U.S.A.	erican Indian		
40	fter de	Funeral	1 Never Married 2 Married 1 3/4	s 2 □ No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Whit			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show he Medical Exatting manal be mailind at	þ	If Yes.	Give r Dates: WWII	1 ☐ Yes 2, TNo Specify:		Specify: Wh	ite		
5-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupation kind of work done during most of wo	orking 161	b. Kind of Business	/Industry		
121	nithin ne. han "	JG II		Farme	DO NOT use retired)	F	arming			
2	Hygie ther t		17. Father's Name (First, Middle, Last)	Larme		me (First, Middle, Mai				
an	d be ental ked o	To Be	Wilbur Walker		Elsie		,			
Maryland	shoul nd Ma marl	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or R		ity or Town, State, 2	Zip Code)		
	and 2 alth a 127 ls		Ruth S. Walker (Wife)	3927	Level Road	Havre de (Grace, MD	21078		
ore	of He of He fiterr		20a. Method of Disposition ★文Burial 2 □ Cremation 3 □ Removal fro	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date 200	c. Location - City or	Town, State		
Ë	Pag ment tent: I		4 Donation 5 Other (Specify)	Harmony F			arlington	, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itame 23a or 28a-1 show amy injury or other treumatic event, the Mudical Ezatufust must be multiful at ODGs.		21. Signature of Funeral Service Licensee	leable ?	2. Name and Address of Facility Tarring—Cargo Fu Aberdeen, Maryla	neral Home	P.A.			
	TESTA.		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause of	t caused the death. Do not en				Approximate Interval Between		
4	Physician		Immediate Cause (Final disease or condition	netastatic	bludder Co	ancer		Inset and Death Months		
R	/Medical		resulting in death)	to (or as a consequence of):				<u> </u>		
l,	Examiner	_	Sequentially list conditions, b. Duck	1- (
$\sqrt{}$	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):						
	xecut and al-trar	xan	triat initiated events	to (or as a consequence of):						
8760,	cate be executed oblysicien and the burial-transit	dlcal E	d							
9	tificat ng phy as th	led								
Вох	death certific attending p	an/N	23b. was decedent pregnant	outcome of pregnancy e birth 2 🗍 Fetal death 3 🗓	Ectopic pregnancy		23d. Date of de	livery Day Year		
.O.	e dea the at hed fo	by Physician/Me		egnant at time of death 5[sknown	Other (specify)		WOITH	Day		
<u>α</u>	that the de ned by the a detached f	Phy	Part II. Other significant conditions contributing to	o death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to	o the cause of death?		
ecords,	88 50 0	d by				1 ☐ Yes	2 □ No 3 P	robably 4 Dunknown		
00	w require s been si should b	Completed				24a. Was an	24b. Were as	utopsy findings available		
α	sician: The law certificate has b irector, page 2 s	E O				autopsy performe 1 ☐ Yes 2 🛣	d? death?	completion of cause of		
Vital	lan: rtifica	BeC	25. Was case referred to medical		26. Place of De	eath (Check only one)	210			
of V	Physician: this certific ral director,	2		☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 ⊀ Residenc	e 6 □Other (Spe	cify)		
2	ing P	on:	i alivatulai S [] i oliuliig	ite of İnjury 28b. Time o fonth, Day Year) Injury	Work?	28d. Describe how	injury occurred			
Sic	ttend death ttor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm, st	M 1 Yes 2 No	28f. Location (Stree	at and Number or B	ural Boute Number		
Division	after after Direction by	Certification:	determined 200. FT	illding, etc. (Specify)	reet, lactory, office	City or Town, S		ar riodio regribor,		
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Examiner: On th		th occurred at the time, date and place avestigation, in my opinion, death occurred					
	To th within To th compl	Me	29b. Signature and title of certifier	mn	29c. License number	29d.	Date signed (Mont	h. Day, Year)		
	_		Dan	111/	D5489	+/	6/12/0	Q		
	1041		30. Name and address of person who completed of	ause of death (Item 23a) (Type,	D5489 hi 14 delphia	Rd :	2/23	7		
	Sta Regist		31. Date filed (Month, Day, Year) 6	. Registrar's Signature						

		State of Maryland / De	partment of Health and I per ME 6856,06/09 effilicate of Death	/06dhb	ne2006	19001
Physici /Medic		1. Decedent's Name (First, Middle, Last) JOHN WRIGHT	WYSONG	2. Date of Death Month April 1	Day 2006	3. Time of Death 2:40 A M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
29	2 0	Prince Georges Hospital	Cheverly		Prince (
Funeral Director		5. Social Security Number 215-32-4743 G. Sex 1 MM 2 F 7. Age (In yrs. last birthd) 73 Yrs Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Pay, Ye 5/5/193	9. Birthp Cour S2 Ma.1	place (State or Foreign ntry) ryland
naturel', or itema 23a or 28a-1 ehow dical Exandrat must be routiled at		10a. State 10b. County 10c. City, Town of	Location		1	0d. Inside City Limits
e a	tor	MD. Prince Georges	College	Park		1 ☐ Yes 2 No
or 28g	Director	10e. Street and Number	10f. Zip Code		Citizen of What Cour	ntry?
23a (6100 West Chester Park	2074	U O	Inited S	tates
ed other than "naturel", or itema 23a or 28a-1 show event, the Medical Examinar must be multied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No tt Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Tan	
a G			cedent's Usual Occupation	166	. Kind of Business/In	
岩	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of wor b. DO NOT use retired)	king	. Kind of Business/in	dustry
9	E O	Elementary/Secondary (0-12) College (1-4or 5+)	ollege Professo	or	Educa	ation
ent,	BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
tic e	To E	Francis Wyson	g Mary	Eliza	beth	Wright
7 Is marke traumatic			ailing Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Zip	Code)
other tr				Jarretts	ville, 1	Id. 2108
r oth		1 Burial 2 Cremation 3 Permoval from State Cemetery, C	position (Name of rematory or other place)		. Location - City or To	
n A		4 □Donation 5 □Other (Specify) White Rose	Crematorium 4/4	/2006 Yo	rk, Penr	nsylvani
eny Inj		21. Signature of Funeral Service Licensee		arrettev	ille, Ma	aryland
**************************************		23a. Part1. Enter the disease, or complications that cause the death. Do not shock, or heart failure. List only one cause on each ne. Mill 1-in	The state of the s	# #V		Approximate Interval Between
cian		Immediate Cause (Final disease or condition	10 morely	-/1/1	MANANAE	Onset and Death
dical niner		resulting in death) Due to (or as a sinsequence of):		11 Um	OV MEDICAL EXAMINA	100
illei		Sequentially list conditions, b.	4	UN LIFTROVE		doip
#S	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	last of	MINITERATION & PROVED		1000
I-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence of);	To the			della
e burial-transit		24 C	eral hammer	Ma		Carre
Ē	dlcai	d.	~ (a) 10 · ~	Tope		- July
use a	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	
stached for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (s <i>pecify)</i>		Month	Day Year
90 GG	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the	ne cause of death?
phone	etec	0	PCIOWID		2010 001100	abiy 4 dollariowii
page 2	Completed	occupital conde	I frontene	24a. Was an autopsy performed 1 Yes 2 1	prior to cor death?	psy findings available inpletion of cause of 22 No
director.	Be	25. Was case referred to medical examiner? Hospital:	Other	th Check only one		
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funer	t i	1 Natural 5 Pending (Month, Day Year) Injur	28c. Injury at Work? 1		auto/fixe	ed object
y the	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm		impacts 28f. Location (Street		
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Meny	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control one) 2 Medical Exeminer: On the basis of examination and/or and manner stated	ath occurred at the time, date and place.	and due to the cause	(s) and manner as st	ated
completely filled in by the fi	Ď.	one) and manner stated. 29b. Signature and the ol certifier	29c. License number	29d [Date signed (Month, I	Day Year)
8		Data Allina	D4(341	4	-onl	2001/
	i	30 Name and address of possess who correlates the of death (the 2001 Time	o Print)	М	pril (1000
			ince George	Hospital	Charco	4, MD
Sta egistr		31. Date liled (Month, Day, Year) JUN 0 9 2006 32. Registrar's Signature	3			τ

Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of Health and	Mental Hygien

Tyrell Demarcus V	1- R	For State	State of Marylan		ificate of D		Re	eg No 200	16 1900
Physician Medical Examine	/ 1	. Decedent's Name (First, M		t alease			2. Date of Deat Month May 29, 20	Day Year	3 Time of Death 0024 hrs
		a. Facility Name (if not insti	emarcus Whit			City, Town, or Location of		4c. County of Deat	
Funeral	5	Prince George Cou		Age (In yrs. las		heverly Under 1 Year If Under	24Hrs 8. Date of Bir	th (MM/DD/YYYY) 9 Bi	rthplace (State or
Director	-	579-11-2476	1 X M 2 F		20 Yrs.	Months Days Hours	Min. 08/28	/1985 Fores	ountryWash., DC
w any	_	0a State 10b. Cou	unty	10c. City, 1	own or Location		· ·		10d Inside City Limits 1 X Yes 2 No
Maryland 28a-f show any d. at once.	₹ M	laryland Pri	nce George's		11	Lanham F Zip Code	11	Og Citizen of What Cou	1 **
death with the Maryland or items 23a or 28a-f sho must be notified at once.		3002 Brig	htseat Road,			2070	6	United	l States
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or rither traumatic event, the Medical Examiner must be notified at once		Marital Status X Never Married 2	Married Armed Ford	lent Ever in U.S es? 2 X No	If Yes,	ecedent of Hispanic Origin specify Cuban, Mexican, F		White, etc.	rican Indian, Black,
rs after ural",	2	A CONTRACTOR OF THE PARTY OF TH	Divorced If Yes, Give Year or Dates: (Specify only highest grade	completed)	16a. Decedent's	s 2 X No specify: Jsual Occupation (Give kii		Specify 116b Kind of Business	Black /Industry
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within siene her tha		12th 7. Father's Name (First, Mid	ddle Last)			sional Clow	n Name (First, Middle, I		-Employed
215- be filed mal Hyg rked off		17. Fauler 3 Name (First, Min	Donald Co	oner			,	e Mattocks	
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 pages I and 2 should be filed within 7 portant: If item 27 is marked other than portant: If item 27 is marked other than 1 filem 2 filem 2 filem 3	= -	9a Informant's Name/Relat	tionship (Type, Print)	-		dress (Street and Numb	per or Rural Route Num	nber, City or Town, Stat	e, Zip Code)
mand 2 s fealth a ten 27 traums		20a. Method of Disposition	ittaker/Moth	20b P	lace of Dispositio	rightseat R	d., #204, Date	Lanham, MD 20c. Location - City o	20706 r Town, State
nore	- 1	1 X Burial 2 Crem 4 Donation 5 Other	nation 3 Removal from	State	ematory or other	orial Park	6/3/2006	Landove	a∞ MD
Caltir		21. Signature of Funeral Ser		THat	22. Nam	e and Address of Facility		uneral Home	
m ឱ្យ E E Physician	+	23a Part Enter the diseas	se, or complications that cau	sed the death.	Do not enter the	4001 Ren	ning Rd	NE Wash est, shock, or heart	Approximate Interval
/Medical	1	failur List only one ca	ause on each line.						Between Onset and Death
Examiner)		or condition resulting in dea		onsequence of).				
	<u>ا</u> ق	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):				
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Box 687 e death certification the attending ped for use as the	Physician/Medical	1 Yes 2 No 9		nt at time of dea n	other	(Specify)).
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit		Part II. Other significant co	onditions contributing to	death but not re	sulting in the und	erlying cause given in Par		obacco use contribute to	
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cord faw req has bee 2 shou	Completed				_		autor perfo	psy prior to rmed? death?	completion of cause of
Rec		25. Was case referred to me	edical			26 Place of Death (1 Yes Check only one)	2 No 1 V	Yes 2 No
Vital ysiciau: this certifi director	음 일	examiner?	Hospital:	patient 2	ER/Outpatient	DOA Other	Nursing Home 5	Residence 6 Oth	er
Division of Vital Records, P.O. pital or Attending Physician: The law requires that to ours after deatheral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be dead		27. Manner of Death 1 Natural 5	28a Date o	f Injury Day,Year)	28b. Time of Inju FOUND:	ry 28c. Injury at Work? 1 Yes 2 ✓	Subject Hai	how injury occurred nged Self	
ision Atteno er death rector: by the	cati	2 Accident	Investigation May 28, 2	2006	2345 hrs	actory, office building, etc		Street and Number or F	Rural Route Number, City
Division Haspital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Homicide	Could not be determined (Specify)	Multi-Famil	y Apt.		or Town, S 2915 Bright	State) seat Road, Lando	over, MD
S .	Medical C	29a Certifier 1 Certifyi (Check only cne) 2 Medica	ing Physician: To the best	examination a	ge, death occurre	at the time, date and place, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as sta and place, and due to	arted the cause(s)
To To	ğ	29b Signature and title of c		neu _		29c. License number		29d Date signed (M	lonth, Day, Year)
1			Chul			O.C.M.E.		May 29, 2006	
CR		30. Name and address of po David Fowler M.D	erson who completed cause Chief Medical Ex	of death (Item caminer 1	^{23a)} 11 Penn Stre	et, Baltimore, MD 2	21201		
St	200	31 Date filed (Month, Day,	Year) Reg	gistrar's Signatu					
Registr	ell'	JUN 0 2	2006	u.	ORIGINAL				

			1 - For State Registrar	State of Maryla	and / Depa	artment of F	lealth and l		giene 9g. No. 2006	1900
I	Physic	cian	Decedent's Name (First, Middle, Last CHARLES					2. Date of Dea Month	th Day Year	3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, give SOUTHERN MARYL		<u>Π</u>	4b. City, Town, o	r Location of Death		26 2006 4c. County of Death PRINCE GE(
	Funeral Director		5. Social Security Number 6. S		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JAN. 9		place (State or Foreign
aryland 2	d 2 should be filed within 72 hours after death with the Maryland th and Manial Hyglene. If a marked other then "neture!, or iteme 23a or 28a-f show treumatic event, it a Madical Examiner must be notified at	To Be Completed by Funeral Director	10a. State MD PRINCE G 10e. Street and Number 2900 ST. CLAIR DR 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grace) Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Last) WILLIE WHITFIE 19a. Informant's Name/Relationship (7)	EORGE S IVE # 413 12. Was Decedent Ever in Amed Forces? A 1 Myes 2 No 1 Myes Give Year or Dates: ucation de completed) College (1-4or 5+)	U.S. 13. 13. 19-11/71: 16a. Deced	HILLS 101. Zip Code 20748 Nas Decedent of Hillers, specify Cuba I Yes, specify Cuba I Yes 2 No I Sent's Usual Occupation work done a colon Work done a colon NOT use retired BLED	Specify: ation luring most of work 18. Mother's Nam MARI:	ecify Yes or No- Rican, etc.)	Og. Citizen of What Cou U.S.A. 14. Race - Amerin Black, White, Specify: B. 16b. Kind of Business/In NONE faiden Sumame)	can Indian, etc. LACK idustry
ımore, M	permit. Pages 1 end 2 Department of Heelth a Important: If item 27 is any njury or other tree		RHOSHANDA CURTIS/ 20a. Method of Disposition 1	DAUGHTER Removal from State RI	Place of Disposementery, crem VERDALE	EW COMB S sition (Name of latory or other place CREMATOR Name and Addres	T SE #2 Y EY JUNE s of Facility J.	WASHINGTO Date 2 2 2006 B. JENK	ON, DC 200. Co. Location - City or To RIVERDALE, M INS FUNERAL , MARYLAND	32 Own, State ARYLAND
,00	hypothesicien and hypothesicie	dicai Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.	quence of):	ENSIO FINOLO FINOLO I'RROF	J	or respiratory arre	Le	Approximate Interval Between Onset and Death Office Advance Ad
The law conject that the death	signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	al death 3 E	Ectopic pregnancy Other (specify)			23d. Date of deliver	ry Day Year
- (50 loo	been signed t	Ď	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the unc	derlying cause giver	in Part I.		cco use contribute to the	
no. The law	certificate hes b	e Completed	25. Was case referred to predical					24a. Was an autopsy performe	prior to com death?	sy findings available inhetion of cause of
Physician.	S di	ToB	examiner? 1 Yes 2 No H		ER/Outpatient	3□ DOA Other	26. Place of Death 4 □ Nursing Hon		ce 6 Other (Specify)	
Attending	. 55	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	_	es 2 No	8d. Describe how	injury occurred	
Hospital or			4 Homicide determined 29a. Certifier Dentifying Phys	28e. Place of Injury - At h building, etc. (Special ician: To the best of my kno	y/	nouseand at the sine	44	Chy or rown,		
the Ho	.= - a	Medicai	(Check only 2 Medical Examinone) 29b. Signature and little of pertition	and manner stated.	ition and/or inve	sugation, in my opin	non, death occurre	d at the time, date	and place, and due to the	he cause(s)
7	₹ 5 8	_ .	iso. Signature and little of demand	 		29c. License r	70		Date signed (Month, Da	
	(6)	3	30. Name and address of person of the ASTOO	mpleted cause of death (Item	n 23a) (Type, Pri	int)	0 , -	1	m) 2090	106
ą	Stat Registra	~	JUN 0 1 2006	32. Registrar's Signa	ture frank	e3-41	D) (un)	pa	m) 2090	2

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23^{Day} Month **Physician** May 2006 Doris Willis 12:05 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday). If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 8, 1 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🖾 F 578-28-1477 1928 Washington, DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ad other than "natural", or itams 23a or 28a-f ahow avant, the Medical Exempler rust be notified at Director Washington Yes 2 No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20011 USA 346 Oglethorpe Street NE a filed within 72 hours after deeth to Hygiene.
Othar than "natural", or Itams 23s Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by Specify: Black 3X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Typist Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Heelth and Mental Hitam 27 is marked others. Be Dorothy E. Contee Frank Robinson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Patterson/Daughter 9900 Woodstream Ct. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Arlington Nat. Ceme. June 14, 2006 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ohnson and Jenkins Funeral Home 716 Kennedy St NW Washington, DC 20011 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Imm fiate Cause (Final Onset and Death
UNKNOWN SEPSIS **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner **PNEUMONIA** UNKNOWN Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): physicien by Physician/Medical use as the the ettending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 0 Month Year Day 4 Pregnant at time of death 5 Other (specify) deteched 9 Unknown 9 TUnknown ፩ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 2 X No 1 🗌 Yes 3 Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a. Was an page 2 autopsy performed?

1 Yes 2 2 No this certificete filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours efter deal a Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier completely (Check only one) within 2 ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 May 25, 2006 D0063738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anjuman Ara 1500 Forest Glen Rd Silver Spring, MD 20910-1484 31. Date filed (Month, Day, Year) State Registrar JUN 0 1 2006

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Antionette Wyatt May 29, 2006 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

Dec. 24, 1925 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🍎 F 046 16 3873 80 Dec. Director Massachusetts Usual Residence of Decedent death with the Maryland 10h County 10c. City, Town or Location in then "neturel", or Iteme 23s or 28s-f show the Medical Exerciper must be notified at 10d. Inside City Limits Directo 1 XYes 2 No Connecticut Hartford Waterford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Josan Drive 06385 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Heelth and Mental Hy important: If Item 27 ie marked oth any injury or other traumatic even Be Thomas LaVolpicelo Anni DiVingzenzo ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16233 Monty Court Rockville, Maryland Richard Wyatt / Son 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State East Lyme Cemetery 6/2/2006 4 ☐ Donation 5 ☐ Other (Specify) Niantic, Connecticut 21. Signature of Funeral Service Licer see 22. Name and Address of Facility Hines Rinaldi Funeral Home BU 11800 New Hampshire Ave Silver Spring, MD 20904 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final **Physician** arrhy Himas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Oronary or ID MIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ettending physicien and for use as the burlat-transit colastes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical MATA 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 💆 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 Yes 2 No 1 Yes Director: After this certific d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours e To the Funerei f 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/29/2006 IN NOSSUL 23091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4915 Auburn Avenue Betharder MD 20314 K. NOSSULIMD 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State JUN Registrar 2006 DHMH 17 Rev 1/2001

For State Registrar

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar			Ce	rtificate	of L	Death		Reg. No	Z U U	U	13	UU:
7	Physici /Medic		1. Decedent's Name (First, Middle, Last) Vera Mae Parks	Wilson						2. Date of De May 25		06 °	reer		of Death
1	Examir		4a. Facility Name (If not institution, give	street and number)					Location of Deat	n	40	c. County of	Death		
		e 20	Bedford Court			b i ab d			Spring If Under 24 Hrs.	100	Montgomer				
7	Funeral: Director		280-24-0224	7. Age	(In yrs. 12	6 Yrs.		ays	Hours Min.	8. Date of Bir (Month, Da Jan • 8	y, Year	920	Ohi	ntry)	te or Foreig
	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						T	10d. fnside	City Limit
	Mary 	ţō	Maryland Montgome	ry	Si	lver S	Spring							1 % Y	es 2 N
	h lhe	Director	10e. Street and Number				10f. Zip Co	ode			10g. C	itizen of Wh	nat Cou	ntry?	
	23a c		3700 International	Drive			2090	6			Un	ited S			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show important: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show injury or other treumatic event, tra Madical Examinar must be notified at ADGE.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No ft Yes, Give Year or Dates:			Was Deceden ff Yes, specify 1 ☐ Yes 2 X	Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)			White,	can Indian etc. .ack	,
Š	72 ho	Completed	15. Decedent's Edu (Specify only highest grade			(Give	dent's Usual C	done d	turing most of wo	rkına	16b. I	Kind of Bus	iness/ln	dustry	
2	ithin of	nple	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	lite.	DO NOT use r	retired)		_	0 0			
22	ljed w lygier ther ti nt, lin		17. Father's Name (First, Middle, Last)	4		CILY	riaygr	oui	nd Direct	ne (First, Middle		.C. Go		nmen	τ
and	d be f	o Be	Henry Parks							Le (unkn					
2	shoul nd Me mark	To	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address (S	treet a	and Number or Ri	•	······································		tate, Zij	Code)	
	aith a 27 is		Clay Wilson III	(son)		5607	Dawes .	Αve	nue, Ale	exandria	, V	A 223	311		
Se,	of He of He r Item		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F	Iomoval from State	20b. P!	ace of Disponentery, cre	osition (Name matory or othe	of r plac	θ)	Date	20c. l	ocation - C	ity or T	own, State	
Ĕ	Pag ment ant:		4 Donation 5 Other (Specify)	delitoral from State	Che				ory 5/3	-		ltsvil	,		
Baltimore,	Depart Mport mport ony inj		21. Signature of Funeral Service License	00/					s of FacilityMc(
,	005 • 0		23a. Part1. Enter the disease, or compl	in the course	ho doath				gia Ave.			. D.C.	. 2	0012 Approxin	nato
3	Physician /Medical		shock, or heart failure. List only or fmmediate Cause (Final disease or condition resulting in death)	Congest Due to (or as a	ive	Heart			9, 30011 43 04.014	or respiratory a				Interval E	Between nd Death
*	Examiner		O CONTROL TO A CONTROL OF THE PARTY OF THE P	Bacteri			rditis							day	ys
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):									
Ć.	execute on end ial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Due to (or as a consequence of):										
68760,	icate be physicie s the bur	Medicai		d	-										
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien end rage 2 should be detached for use es the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \(\frac{1}{2}\) No 9 □ Unknown	1 ☐ Live birth 2	ff yes, outcome of pregnancy 1						23d. Date of deliver			ery Day	Year
۵.	that the hold by detail	y Ph	Part fl. Other significant conditions con	ntributing to death but	not resu	tting in the u	inderlying caus	se give	en in Part I.	23e. Did t	obacco	use contrib	oute to t	he cause	of death?
Sp	quires on sign	ed by	Hypertension							1 🗆	Yes 2	2 □ No 3	B □ Pro	bably 4	Winknow
Division of Vital Records,		Completed								24a. Was auto perfo 1 Yes		pri de	or to coath?	opsy finding ompletion of	gs available of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	In and to be				1 01		ath (Check only	one)				
5	Physic this c	. To	1 ☐ Yes 2 ŽNo 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		ER/Outpatie		Oth	44E Nursing r	fome 5 ☐ Resi				(y)	
LO	ding l h. After funer	tion	1 🖾 Natural 5 ☐ Pending	(Month, Day	Year)	Injury	M 200.	fnjun Worl	γαι k? Yes 2□No	Zod. Describe	HOW HIP	ury occurre	u		
Divisi	l or Attending Physicien: after death. Director: After this certific I in by the funeral director,	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of frigue building, etc.	ry - At ho (Specify	me, farm, st	reet, factory, o			28f. Location (City or To			r or Rur	al Route N	lumber,
_	To the Hospital or within 24 hours after To the Funerel Diccompletely filled in	Medical C		sician: To the best of ner: On the basis of and manner state	examinat										e(s)
)	To th within To th compl	Me	29b. Signature and talle of certifier	W) i	1.10		384	e number 57			ate signed,			r)
,	5		30. Name and address of person who con Nakul Goyal, M.D.					ve,	Silver	Spring,		2090			

State Registrar

			1 - For State Registrar	State of I	Marylan		artmen rtificat					Reg. No	2000	19	010
	Physici	20	1. Decedent's Name (First, Middle, Las	et)							Date of D Month	eath Da	y Year	3. Time	of Death
	/Medic		Anne Forcier Wat								May		2006	7:48	Α Μ
	Examin	er	4a. Facility Name (If not institution, give		er)		,		Location of			40	c. County of Deat	h	
			3 Country Woods (5. Social Security Number 6. S		Ago (In yes	last birthday)	Gai	ther	sburg If Under		8. Date of B		lontgome		or Foreign
	Funeral Director			□M 2X0F	53	Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year		hplace (State untry)	di Foleign
			Usual Residence of Decedent				1				Dec 7,	193	Z MISS	souri	
	ehow		10a. State 10b. County			y, Town or Lo								10d. Inside	
	e Ma	cto	MD Montgome	ery	Ga	ithers	burg							1 X Ye	s 2 🗆 No
	ith 다 or 28	Funeral Director	10e. Street and Number				10f. Zip					10g. C	itizen of What Co	untry?	
	ath w	2	3 Country Woods C					878					ted Stat		
	er de	L L	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decede	s?	.S. 13.	Was Dece ff Yes, spe	dent of Hi cify Cuba	i <i>s</i> panic Ori in, Mexicar	igin? (Spe n, Puerto f	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		
36	rs eft	by F	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 If Yes, Give Year or Date			1 🗌 Yes	2 ∏ №	Specify:				Specify: W	nite	
21215-0036	within 72 hours elter death with the Maryland ane. than 'natural', or Iteme 23a or 28a-f ehow ha Madical Examinar must be nutilised at		15. Decedent's Ed			16a. Dece	dent's Usu	al Occup	ation			16b.	Kind of Business/	Industry	
215	hin 7	ple	(Specify only highest gra	Colfege (1-4	or 5+)	life.	kind of wo DO NOT u	se retired	du <i>ring m</i> os ()	it of workir	ig	Engi	neering	Firm	
N	filed wil Hygien other the	Completed		4		Admi	nistr	ativ			-				
2	2 should be filed withir and Mental Hygiene. is marked other than surnatic event, the Me	Be	17. Father's Name (First, Middle, Last)								(First, Middl		n Sumame)		
yla	should be find Mental Harked of	၉	Guy S. Forcier								Marsha				
Maryland	12 sh h and h and f is m		19a. Informant's Name/Relationship (Scott Watson / Hu	• •			•					-	or Town, State, 2		
	ss 1 and 2 should be filed within 72 hours effer death with the Maryla of Heath and Mental Hygiene. I fitem 27 is marked other than "natural", or Iteme 23s or 28s-1 ehov if item 27 is marked other than "natural", or there traumatic event, the Madical Examinar must be notities at		20a. Method of Disposition		20b. F						ate		ocation - City or		
jo	Pages ment of I ant: If its		1 ☐ Burial 2 【X Cremation 3 ☐		110	tace of Disposemetery, crea			1		2006				
Baltimore,			4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	<u></u>	IN &	ational						ral	ls Churc 's Sons	Too	
Ba	permit. Departr Imports eny inj		Alithania R	Reade									gton DC		
			23a. Part1. Enter the disease, or com	plications that cau	sed the deat								geon Do	Approxim	ate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on eac Breast		er								Onset and	d Death
1	/Medical		disease or condition resulting in death)	a	as a conseq									5 Yea	rs
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	₽ #	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):									
	ite be executed iysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C											
760,	cian s	cal E		Due to (or	as a conseq	(derice di).									
687	w requires thet the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		•	d						-					
×	death certifica e attending ph id for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy		_					23d. Date of del	ivery	
Вох	atter d for u	clar	in the past 12 months?		n 2∐Feta itattime ofd		⊒Ectopic p ⊒ Other (s _t		'				Month	Day	Year
P.O.	the car	hys	9 Unknown	9□ Unknow	n										
	requires thet the een signed by th nould be detache	by P	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the u	inderlying o	ause grv	en in Part I	l.	23e. Did	tobacco	use contribute to	the cause of	death?
Records,	equire en sig ould b	ed									1	Yes 2	2⊠No 3∏Pr	obably 4	_Unknown
သူ	awre as ben 2 sho	plet									24a. Wa	s an	24b. Were au	itopsy finding	s available
	The law sete has page 2:	Completed										formed?	death?		Cause of
ita	Physiclen: Th r this certificete real director, pag	Be (25. Was case referred to medical examiner?							e of Death	(Check only	опе)			
¥ \	hysic his ca	은	1 ☐ Yes 2 ☑No			ER/Outpatie			40140				6 □Other (Spe	cify)	
בו	5 a a	<u>6</u>	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of finjury		28c. fnjur Wor			28d. Describe	how inj	ury occurred		
Division of Vital	tend death tor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not b		4.5		М		Yes 2 🗆		204 1	/C44		(0) (
Ξ	or A	iti	4 Homicide determined	building	, etc. (Special	ome, farm, st fy)	reet, ractor	у, опісе		-	City or T		and Number or Ri te)	arar Houte IVI	moer,
1	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	C	29a. Certifier 1[本Certifying Ph	ysician: To the b	est of my kn	owledge, deat	th occurren	at the tin	ne, date ar	nd place a	and due to th	e Cause/	s) and manner as	stated	
	• Fur	edical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examina	ation and/or in	vestigation	in my o	pinion, dea	ath occurre	ed at the time	date a	nd place, and due	to the cause	(s)
	To th within To th sompl	Me	29b. Signature and title of certifier		1		29	c. Licens	e number			29d. D	ate signed (Mont	h, Day, Year)	
			1 Joseph	n. Hag	zerty	-mo)	I	3240	7			Jur	ne 1, 20	06	
	20		30. Name and address of person who	completed cause	of death (Iter	п 23а) (Туре									
_ 4	20		Joseph M. Hagger						#300	O Roc	kville	, MI	20850		
3	St. Regist	ate rar	31. Date filed (Month Day Year)	2006	jistrar's Signa	ature	mel	,							

			State of Maryla State of Maryla Registrer	•	artment of H		d Ment		ene ₂ 0	06	9	011
			Decedent's Name (First, Middle, Last)					ate of Death Ionth	Day	Year	3. Time o	f Death
	Physici: /Medic		Dorothy Gertrude Wood				Ma	ay 26,	2006		1:55	p.m.
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death		4c. County			
			6005 Bicknell Road	the state to the	Indian I		Hec la D	-1 -1 Di-1	Char			
н	Funeral		1014 2015	rrs. last birthday) Yrs.	Months Days		Min /A	ate of Birth Month, Day,	^{Year)} 191 5	Coun	lace (State try) Land	or Foreign
	Director		216-78-8889				Dec	. 0,	1913	riat y	Taria	
	/land			City, Town or Lo	cation					1	0d. Inside C	City Limits
	Many	to	Maryland Charles	Indian	Head						1 🗌 Yes	2 X No
	n 28g	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Coun	try?	
	1h wit	aD	6005 Bicknell Road		2064	0			U.S.A	<u>.</u>		
	dea Fine	Funeral	11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin' in, Mexican, Pi	? (Specify Yuerto Ricar	res or No- i, etc.)		ce - Americ ck, White,		
98	or It	Y.	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☒No		1 □ Yes 25 No	Specify:			Specif	y:		
g	72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f ehow cites Expolrer must be notified at	Q D	3 Widowed 4 Divorced Year or Dates:	163 Doco	dent's Usual Occup	ation		1	6b. Kind of B	Whi		
21215-0036	- 3	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of	f working		OD. KING OF D	1033711	Justry	
72	within then the	mo	Elementary/Secondary (0-12) Cotlege (1-4or 5+)	н	omemaker				Her H	Tome		
	be filed within tal Hygiene. Id other than event, the Mare	Be C	17. Father's Name (First, Middle, Last)		On Canada	18. Mother's	Name (Fire	st, Middle, M				
a	o ≅ o •	To B	William B. Rhodes			Gerti	rude 1	Huntt				
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number o	or Rural Rou	ite Number,	City or Town	, State. Zip	Code)	
	and 2 salth n 27 i		Mary R. Grimes Daughter	6005	Bicknell	Rd., 1	India	n Head	·			
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	 Place of Dispo cemetery, crei 	osition (Name of matory or other place	June	1. 20	006 2	0c. Location	- City or To	wn, State	
Ĕ	nit. Pages artment of l ortant: If its injury or o		4 ☐ Donation 5 ☐ Other (Specify)	st. Char.	les cemet	ery		I	ndian	Head,	Mary	land
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	22	2. Name and Addres	ss of Facility Funeral	l Home	e, P.A	•			
_	70 F # 0		23a. Part1. Entry the usease, or complications that caused the	1668	4270 Hawt	horne I	Rd., :	Indian	Head,	Md,	20640 Approxima	
ш			shock, of ea railure. List only one catuse on each line.	eath. Do not en	ter the mode of dyin	ig, such as car	rdiac or res	piratory arres	o . (Interval Be Onset and	tween .
1	Physician		tmmediate Cous (Finat disease or of tion resulting in death)	NCKE	OHE	BIR	1000	1	200	177	XM	1 Pro
	/Medical Examiner		to (or as a con	servence of).	0000	+ OA		.)		J	W/.	.),
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	a dear	7 00	me				Ju	~
	uted I Insit	를	Cause (Disease or injury	HITOS	TE BY	2EAST	TCA	NRSE	wtol	1 1 14	IGN	Low.
ć	te be executed ysicien end ie burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a con	sequence of):						COVI		<u> </u>
68760	ate be executed hysicien end the burial-transit	cal	d									
68	death certificat attending phy d for use as th	Jed	AC CCAMA C.						1			
Вох	death certifics e attending ph of for use as th	an/h	tF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ I		∃Ectopic pregnancy	,			1	ate of delive	-	Year
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 215 No 9☐ Unknown	of death 5	Other (specify)					Ortin	Day	1 641
P.0	res thet the de igned by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not	roculting in the u	endorhija a sauca and	on in Part I		23e Did tob	acco use con	tribute to th	on cause of	death?
Š,	law requires thet the as been signed by th 2 should be detache	Š	Part II. Other significant conditions contributing to death but not	resulting in the d	inderlying cause giv	en in Fait i.		1 □ Ye			ably 4	
Ö	w requir been si should	etec					_	-				
Vital Records,	9 4 6	Completed					- '	24a. Was an autopsy perform	ed?	prior to coldeath?	psy findings mpletion of	cause of
a			25. Was case referred to medical			00 50				1 🗆 Yes	2 No	
₹		o Be	examiner?	2 ER/Outpatier	nt 3 DOA Oth	26. Place of			nce 6 🗆 Oti	her (Specif	w)	
o	Phys ar this aral di	1: To	27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Yea						w injury occu		·/	
ion	Attending r death. ector: After by the fune	atlo	1 Anatural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury		k? Yes 2∐No	,					
Division	Atte ecto by th	110	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of Injury - building, etc. (Sp.	At home, farm, st	reet, factory, office			ocation (Str.	eet and Num State)	ber or Rura	il Route Nur	nber,
Ö	rs effe	Certification:	50,000,000,000									
	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	edical	29a. Certifier Certifying Physician: To the best of my (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.									s)
	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number		29	d. Date signe	ed (Month,	Day, Year)	
	F 3 F 8		12 mm 10 16/11	1 m	() ()	1201	620	1	5	13,	0/0	6
(~	36 Name and address of person who completed cause of death	(Item 23a) (Type.	Priqt)		(1	0	Y	1	
\	DB 6		11-chropolate	TOO.	m) my	11,0	NA	10 C	we	M	dze	50 X
	Sta		31. Date filed (Month, Day, Year) JUN 0 2 2006	ignature	Courtes			1				
	Regist	rar	JUN 0 2 2006 Acres	10 19								

06-03677 Jamier Walston

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

imer vvaiston		- For State Criticate of Death legistrar	Reg.	No. 200	6 1901
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Da May 30, 200	ay Year 6	3. Time of Death 0516 hrs
,		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Death Salisbury	, , , , , , , , , , , , , , , , , , , ,	4c. County of Death	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9 Birt	
Director		N/A 12 F N/A Yrs. Months Days Hours Min.	5/23	Foreig Cor	intry) MD
any	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	흱	MD Wicomico SALISBURY 10e. Street and Number 10f Zip Code	10a	Citizen of What Cour	1 Yes 2 No
ith the Mar 23a or 28a notified at	E E	206-1 WINTER BORN LANE 21804		US	A
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. West Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of		14 Race - Ameri White, etc.	can Indian, Black,
after de ral", or	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1 Yes 2 No specify:	- Co		ack
72 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired to the property of the control of the property of the prop	red)	6b. Kind of Business/I	ndustry
within Jiene	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, Mai	N/A	
21215-0036 Muld be filed within 72 hours at Mental Hygiene marked other than "natural c event, the Medical Examin	8	JADGEN WALLOP SHAM	STIA	WALSTO	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	의	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F SHANT(ALL) ALSTAN MOTHER 206-1 WINTERBORN	Rural Route Numbe		Zip Code) 2 1804
imore, MC Pages 1 and 2 s ment of Health at tant: If item 27 or other traums	Ì	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	Oc. Location - City or	Town, State
Baltimore, permit Pages I an Department of He Important: If ite		4 Donation 5 Other Specify ST, MARY'S MISSION-BAT 6/	3/06 SUNIE S	PRINCESS	NNE, MA
Balti permit Departu Import injury		Procella Cound 917-W. ISABELLA	ST. SAC		
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries	r respiratory arrest,	snock, or neam	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
d sit	Examiner	(Discass of it jury it is it itioned events resulting in death). Last			
760, icate be executed physician and the burial - transit	Medical E	UNPENDED AMENDED			
3760, ficate be g physic		IF FEMALE: 23c If yes, outcome of pregnancy 23b. Was decedent pregnant in the part 12 months? Ectopic pregnancy 2 Fetal death 3 Ectopic pregnancy 3 Ectopic pregna	ancy	23d. Date of delivery	Day Year
Box 687 he death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown			
Records, P.O. Box 687 The law requires that the death certific cate has been signed by the attending I page 2 should be detached for use as the state of the stat		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		cco use contribute to	
ords, P.O. w requires that the is been signed by t should be detache	ted by		1 Yes	2 No 3 Prok	topsy findings available
Division of Vital Records, ral or Attending Physician: The law requir rs after death. "I Director: After this certificate has been so led in by the funeral director, page 2 should I	Completed		autopsy performe 1 ✓ Yes 2		ompletion of cause of
tal Reco cian: The law certificate has	Be Co	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other, 4 Nursing	only one)		
of Virtual ding Physical After this funeral din	ပ	1 ✓ Yes 2 No 28b Time of Injury 28c Injury at Work?	28d Describe how		·,
sion variendin death.	atior	1 Natural 5 Pending Unknown 1 Yes 2 No No No Notice of the Natural 1 Natural 1 Natural 2 No No Notice of the Natural 1 Natural 2 No No Notice of the Natural 2 No No No Notice of the Natural 2 No	Infant assaulte		ral Pouta Number City
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Other (unknown) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Stat unknown, ,		ral Route Number, City
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the cause(s at the time, date an	s) and manner as star d place, and due to th	red e cause(s)
To wit	Me	29b. Signature and title of certifier 29c License number		29d. Date signed (Mo	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)		May 31, 2006	
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 0 2 2006 32. Registrar's Signature			

06-03/03 Please Type or Print in Black Indelible Ink Edward Thomas White State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 31, 2006 Medical Examiner 0600 hrs EDWARD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 903 A Booth Street Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director Country) Yrs MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ALISB Pages 1 and 2 should be filed within 72 hours after death with the Maryland 1CDM1CD Director 10e Street and Number 10g Citizen of What Country' 903A BOOTH 2180 Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black 12 Was Decedent Ever in U.S. Armed Forces? Never Married 2 Married Widowed 4 Divorced Yes. Give Year Yes 2 No specify. Specify ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 'e event, the Medical 21215-0036 ASSEMBLER of Health and Mental Hygiene to I fitem 27 is marked other the other transatic event, the Med 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surna Be ERMAN ٩ 19a. Informant's Name/Relationship (Type 19b. Mailing Address SALISBURY HILLIARD - DAUGHTER MD 21801 BARBARA SECOND Place of Disposition (Name of cemetery crematory or other place 1 Burial 2 Cremation 3 Removal from State mportant: SALISBURY Donation 5 Other Specify ö 21 Signature of Funeral Service Licensee 22. Name and Address of Facility the mode of dying such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** failure, List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed hysician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e Did tobacco use contribute to the cause of death? o contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Seizure Disorder Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 fo the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital. Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes After 27. Manner of Death 28a, Date of Injury (Month, Day, Year 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural 1 Yes 2 No 5 | Pending within 24 hours after death To the Funeral Director: the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. June 1, 2006

State 31. Date filed (Month Registrar

DHMH 17 Rev 1/2001

Laron Locke MD

Name and address of person who completed cause of death (Item 23a)

0 2 2006

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

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Ш	Funeral	- 1	5. Social Security Number 6. Sex 178 - 34 - 9796	/ 2□ F	Let	ast birthday) Yrs.	Months		Hours	Min.	8. Date of (Month)	Day,	Year) 1945	Pin Con	place (State or Foreign Intry)
7	Director	-	Usual Residence of Decedent		QU						OCT.	3.1	1710	11911	13gtva III A
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside City Limits
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(0	within 72 hours after death with the Maryland ene: then "neturel", or iteme 23a or 28a-f show the Medical Exactinat reseat the notilined at	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marned	. Was Decedent E Armed Forces? 1 XYes 2 N			If Yes, spe	city Cubai	n, Mexicar	n, Puerto	ecify Yes o Rican, etc.	.)	Bi	ack, White	
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Maryland	d be l	To Be		LAS W	citi	Ams			4 .				eth		SER
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ore,	of He of He rother		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State	20b. P	lace of Dispo emetery, crea	sition (Na	me of	1	- [Date		Oc. Location		
Ĕ	Pagement:		4 Donation 5 Other (Specify)	noval nom State	Chic	canuxe	n U.M	.Ch.	Cen.	05/2	22/200	16 (hicam	uxen,	,MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Department of Health and Mental Hygiene Unportent: If item 27 Is marked other then "nature!, or items 23a or 28a-f show emportent: If item 27 Is marked other then "nature!, or items 23a or 28a-f show enjury or other traumatic event, ite Medical Examination at any one.		21. Signature of Funeral Service Licensee Michael O. Ray		D∇R	1	2. Name ar	_		•	vice,	, P. A	.,LaP	lata,	MD 20646
	9) 9 ₀		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death	h. Do not ent	ter the mod	de of dyin	g, such as	cardiac	or respirato	ry arre	st,		Approximate Interval Between
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Вох	death certifica e attending ph id for use as ti	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome	2 Feta	Ideath 3	Ectopic p						1	ate of deli Ionth	very Day Year
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	requires thet the been signed by th hould be detache		Part II. Other significant conditions cont	nbuting to death be	ul nol res	ulting in the u	ınderlying	cause give	en in Part I	1.	23e.	Did lob	acco use co	ntribute lo	the cause of death?
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	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best er: On the basis of and marker sta	examina	owledge, deal ation and/or in	th occurred rvestigation	d at the tin n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to red at the t	the ca	use(s) and r	manner as a, and due	stated. to the cause(s)
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16	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature			-11 50	TO M		VI I	MILA.	411-2C	IUU

State of Maryland / Department of Health and Mental Hygiene? 1 - State MEND#20b, perFH, 6/1/06, DPS, MOCO Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:30 am May 30, 2006 Ronnie Lee Yates /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 1 M 2 □ F 223-80-4918 53 Yrs 29,1952 Dec. Virginia Director Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d Inside City Limits 10a State ir than "neturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Clinton Directo MD Prince Georges 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20735 U.S.A 9211 Stewart Lane Funeral ist. Peges 1 and 2 should be filled within 72 hours after deeth a criment of Health and Mental Hygiene.

criant: if item 27 ie marked other than "neturel", or Items 23 injury or other trsumatic event, the Medical Examinating Pust. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status I∐Yes 21⊠No 1 ™ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Morris Yates, Sr. Viola Mae Washington ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7594 Orchard Ct. Manassas, Va. 20109 Robert M. Yates, Brother 20b. Place of Disposition (Name of 06/05%06 20c. Location - City or Town, State 20a. Method of Disposition Ebenezer Bapt. Church 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/5/2006 Midland, Va. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Ames Funeral Home, Inc. 21. Signature of Funeral Service Licensee ir por 8914 Quarry Rd. Manassas, Va. 20110 Ames 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHEMIC OBSTrucTive Lung **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time ol death 5 Other (specify) the th 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 99 1 X Yes 2 No 3 Probably 4 Unknown pieted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Com 1 Yes 2 No tet or Attending Physicien: The safer death.

It after death.

In Director: After this certificate on the funeral director, pe 25. Was case referred to medical 26. Place of Death | Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier 29c. License number D35206 Willia V-anners 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road Fort WASHINGTON William T. TANNER My 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygien® | | 190 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30 P.M May 2006 Katherine Yaksich 27, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. May 3, 1931 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 75 Yrs Ohio Director 008-22-0609 Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County in then "natural", or items 23s or 28s-f show Maryland Montgomery Rockville I Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11700 Ibsen Drive 20852 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or ita 1 Never Married 21X Marned Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 XNo Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic avant, ILI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William John McNiff Lucile Dascomb ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11700 Ibsen Drive, Rockville, MD 20852 Sam Yaksich/ Husband 20b. Place of Dispussion of other place!
Geo. Wash. University may 2 2006 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2.7 Washington, D.C. 4 ☑Donation 5 ☐ Other (Specify) 21. Similature of Juneral Simile License 22. Name and Address of FacilityColumbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has al director, page 2: 2⊠ No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospice1 ☐ Yes 225 No 얼 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation i Diractor: / d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by within 24 hours after or To the Funaral Dirac completely filled in by determined 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35635 May 28, 2006 Mill 20855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster

DHMH 17 Rev 1/2001

State

Registrar

Joseph Kaplan, M.D.

1 2006

31. Date filed (Month, Day, Year)

JUN

parte

Registrar's Signature

Rockville, MD

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 354 am Month **Physician** Mary Addison me 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Maryland General Dital altimuse NA If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 12-5-13 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 💢 F 220-18-3561 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hyglane. Important: if item 27 is marked other then "natural; or iteme 23e or 28a-1 ehow any injury or other treumatic event, it a Medical Examinar must be rediffed at once. 1 ☑ Yes 2 ☐ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 Madison Ave. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautican Beauty Shop 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Η. Davis Charles Missouri Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmond Addison Husband 1803 Madison Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6-19-06 Arbutus Mem. Pk. Arbutus, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. dig wan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mmute /Medical Due to (or as a consequence of): 12 hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical igned by the attending phys be detached for use as the 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Linknown Part IJ, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours efter death.

To the Funeral Director: After thi completely filled in by the funeral. 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Acritying Physician: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 10 31. Date filed (Mortifi, Day, Year) 32. Registrar's Signature State JUN 1 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylan	•	cate of De			Reg. No. 2006	5 19018
			Decedent's Name (First, Middle, Lest)				2. Date of Dee Month		3. Time of Death
1	Physici /Medic		FRANK ALBANY			City, Town, or Loc	JUNE	10 206	
	Examin	er	4a Fecility Name (If not institution, give street and number)	TER	40.	0.0	MORE		th
	-		HARBOR HOSPITAL CEN 5. Social Security Number 6. Sex 7. Age (In yrs.	lest birthday) If Ur		f Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign ountry)
	Funeral Director		214-18-5091 1 ¹ M ² D F 83	Yrs. Mont	iths Days	Hours Min.	Feb 27	, 1923 N	ew Jersey
	D >		Usuel Residence of Decedent 10a. State 10b. County 10c. City	ty, Town or Location					10d. Inside City Limits
	shov shov	ō	Maryland N/A	Baltimore					1⊠Yes 2□No
	the N	rect	10e. Street end Number		f. Zip Code			10g. Citizen of What Co	puntry?
	h with	Funeral Director	3514 Horton Avenue		21225	5		USA	
	r deat	ner	11. Marital Status 12. Was Decedent Ever in U, Armed Forces?	,S. 13. Was De	ecedent of Hisp specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
20	be filed within 72 hours effer death with the Merylend Hygiene. A Hygiene. A dether than "natural", or items 23s or 28s-f show dether than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	by F.	1 Mover Married 2 Married 1 Mover Married 2 Married 1 Mover Married 1 Mover 1	1 □ Y€	es 2⊠No S	Specify:		Specify:	White
ဍ	tural	8	15. Decedent's Education	16e. Decedent's l	Usual Occupation	on		16b. Kind of Business	
212	thin 7:	Completed	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)			ing most of workin	ng	Acme Mark	o.t
7	ed wil	Con	10 0	Warehou		O. Mark and a Marma	(Circh Adiddle	Maiden Sumame)	=
and	be fill be fill be of the orth	Be	17. Father's Neme (First, Middle, Last) Charles Albany		"		A. Mart		
<u> </u>	should and Men marke umatic	၉	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Add	dress (Street and			r, City or Town, State,	Zip Code)
Ž	end 2 s ealth er n 27 is er trau		John J. Albany (Brother)	5400 Pa	ark Road	d, Baltir	nore, M	aryland 2	1225
Ze,	este of Hea Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Place of Disposition cometery, crematory	(Name of		Date	20c. Location - City or	Town, State
<u>Ĕ</u>	Pages ment of ant: If Its ury or o		4 □ Donetion 5 □ Other (Specify) C6	edar Hill				Baltimore,	Maryland
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Insportant: If them 27 is marked other than "natural", or itema 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Kevin E Ecke	MCCu	F Patal	of Facility yniak Fu	neral H Balt	ome, P.A. o., Md. 2	1225-1856
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between
1	Physician								Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	NIA					INEGIC
		er	Due to (o	or as e consequence					2 WEEKS
	uted d ensit	edicai Examiner	D			1			
9	tificete be exacuted ig physicien end es the buriel-trensit	i Ex	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ES ME	FLLIT	us			>34EHRS
68760,	cete b physic the b	dica	resulting in death) Last	or as a consequence					>3YEARS
	certifi nding use es		L . CHRONIC	REV	JAL	BLSET	tse		> STEATES
<u> </u>	deeth e atter	icia	Part II. Other eignificent conditions contributing to death but not res	sulting in the underly	ing cause given	in Part I.	23b. Did t	obacco use contribut	e to the cause of death?
P.O. Box	requires thet the deeth cer been signed by the attendir should be deteched for use	by Physician/N	COMPRESSION FRACTUR	= 05	LUMB	(AD	101	/ee 2□No 3ᡚ	robably 4 ☐ Unknown
ds,	ires th signed d be d					3,715	24a. Was	an autonsy 24h	Were autopsy findings
Sor	v requ	Completed	SPINE BUETO 08T	EOPOR	Rosis			rmed?	available prior to completion of cause of death?
æ	The lew ete hes t page 2 s	ф					101	109 21 No .	1 ☐ Yes 2 ☑ No
ta	an: T tificet tor, pa	BeC	25. Was case referred to medical		2	26. Place of Death			
Ž	Physician: rthis certific rral director,	2		ER/Outpatient 3		4 Li Nursing Hor		lence 6 Other (Spe	ecify)
Division of Vital Records,	Ing Pt	Certification:	27. Man of Death 1 Neturel 5 ☐ Pending (Month, Dey Year)	28b. Time of Injury M	28c. Injury a Work?	t 2 s 2 □ No	28d. Describe h	low injury occurred	
isic	Attending or deeth.	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h. building, etc. (Specification of the second o					Street and Number or F	lural Route Number,
2	s effer s effer il Dire	Certi	4 ☐ Homicide determined building, efc. (Specif	<i>y)</i>			City or Ton	m, State)	
	To the Hospital or Attending Physician: The lew requires that the deeth cen within 24 hours stert edeath. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be deteched for use	edical (29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of exemina end manner stated.	wiedge, deeth occur ition end/or investiga	irred at the time, ation, in my opin	date and place, a lion, death occurre	and due to the ded at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier		29c. License n			29d. Date signed (Mon	th, Day, Yeer)
	1		Abolul fogei		RES	5 00		JUNE, 10	2006
5	t da		30. Neme end eddress of person who completed cause of deeth (Item	n 23e) (Type, Print)	VIII C	TO PET D	AT IM	NOT MADNI	AND 21225
	Sta	to	31. Dete filed (Month, Dayly Year) 6 2001 32. Registrer's Signa		10000	TRULI E	אונו ווונ	THE HITTING	71100 4126-3
	Sta Regista		2014 T. 9 7009	Si Signal	and the state of t				

DHMH 16 Rev 6/95

Amend item 9 per in 806 6-16-06 vt. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death UDER SON th 2006 JUNE 12:30D LEN **Physician** /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANDALLSTOWN RANDALISTOWN Baltimore 8. Date of Birth 7. Age (Invrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country).
 M. **Funeral** 217-56-709 Min. Months Days Hours 1 □ M 2 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland And De Oc. City, Town or Location 10b. Count 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exaction must be notified at MI 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1126 West Pratt Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Retail Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Lansford Fitzgerald THeresa Catherine DiPinto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3831 Wilkens Avenue, Baltimore, Maryland 21229 Robin Rebecca DeVault / Dau. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Denation 5 Other (Specify) Cedar Hill Cemetery 6/15/2006 Brooklyn:Park, Maryland 21. Signature > Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician sepsis disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Renal Diseaso. Sequentially list conditions, Tarry, leading to minimal accause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ M P.O. detached been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 200 Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 0 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Division 5 Pendino 1 Natural 1 ☐ Yes 2 ☐ No hours after death. investigation filled in by the 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 within 24 hours a To the Funeral (1 [Leatlifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0056414

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

of death_(Item 23a) (Type, Print) Randa I Istown

Koad

2006

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 2006 **Physician** 11, 11:25 PM June HAMIDAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Jan. 24, 1920 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 2 XF 181-64-0154 86 Guyanina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other than "natural", or itema 23a or 28a-f ahow vant, the Medical Examinar must be cottilled at Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 21703 Appletree Court USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Guyannese Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Nowidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 4 of Heelth and Mental Hygie Heem 27 is marked other in other traumatic avant, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abdhud Hack Magidan Hamidan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kulsum Bepat 1418 South 12th st. Philadelphia, PA 19116 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 14, Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philadelphia, PA Forest Hills Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease shock, or heart fail bra. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between list only one cause on each line. Onset and Death Immediate Cause (Final disease or condition PULMONARY HIBROSIS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Copp EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68766 attending physicien for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEM MIA 3 Probably 4 Wunknown APLASTIC 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 1 No 2 No 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ t) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Prertifying Physician: To the best of my knowledge, death accurred at the time, date and class, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0047951 6-12-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TOLL HOUSE AVE. FREDERICH MD 21701 SIBTE A. KAZMI, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mar	yland / D	epartme <i>Certifica</i>	nt of Healt te of Dea	th and M		enę? 🖟 (g. No.	19022	
Physici	an	Decedent's Name (First, Middle, Last)						Date of Death Month	Day	3. Time of Death	
/Medic				utdorf				June		2006 4:10 P M	
Examin	er	4a. Facility Name (If not institution, give : 15720 McKendree Re			4b. City	, Town, or Locat Brandyw			4c. County o		
		5. Social Security Number 6. Sec		(In yrs. last birth	nday) If Und		nder 24 Hrs.	8. Date of Birth		nce George's	
Funeral Director			M 2XIF 9	r	rs. Months	Days Hou	urs Min.	8. Date of Birth (Month, Day, Jan. 26,	1911	9. Birthplace (State or Foreign Country) Ohio	
be filed within 72 hours after death with the Maryland and bylygiene. Bylygiene bylygiene dither then "natural", or items 23a or 28e-f show dother then "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	Director	10a. State 10b. County Maryland Prince Ge 10e. Street and Number		10c. City, Town	Bran	ndywine		10	- Citizan et M	10d. Inside City Limits 1 ☐ Yes ② No	
3a or		15720 McKendree Rd.				2061	.3	og. Citizen of What Country? United States			
, or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married XXWidowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			edent of Hispanic ecify Cuban, Me: 2X No Spe		ecify Yes or No- Rican, etc.)			
n "natural fedical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)			Decedent's Us (Give kind of w life. DO NOT	ual Occupation ork done during use retired)	most of work	ing 1	16b. Kind of Business/Industry		
the	mo	Elementary/Secondary (0-12)	Colfege (1-4or 5+)			memaker			Own	1 Home	
marked other	To Be C	17. Father's Name (First, Middle, Last) William Curtis Cowling Grayce LaV						aiden Sumame LaVerne	_		
th and N		19a. Informant's Name/Relationship (Ty Loyd Butdorf / Son	,	4.				al Route Number. Brandywi		State, Zip Code) 20613	
Heal Heal tem 2		20a. Method of Disposition		20b. Place of cemetery						City or Town, State	
ant of ht: If I		1 ☐ Burial 2 X Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			other place) cematory	6/14	./06	Beltsv	ville, MD	
Department of Health and Menta Important: If Item 27 Is marked eny Injury or other treumatic ev once.		21. Signature of Funeral Service License	-01358		22 Name Rapp	and Address of F Funeral	acility and C	remation	Servic	es	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused th	ne death. Do no				ver Spri		20910 Approximate Interval Between	
hysician and provided as the private	cal Examiner	finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Congestive Heart Failure Due to (or as a consequence of): Hypertensive Cardiovascular Disease Due to (or as a consequence of): C. Due to (or as a consequence of):								Onset and Death	
ate has been signed by the ettending phy bage 2 should be detached for use as the	by Physician/Medic	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year			
signed b	d by Pl	Part II. Other significant conditions con	cant conditions contributing to death but not resulting in the underlying cause given in Part I.						d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknow		
	Completed	24a. Was an autopsy perform							an 24b. Were autopsy findings available sy prior to completion of cause of death?		
sertific ector,	Be	25. Was case referred to medical examiner?	lospital:				Place of Death	(Check only one)		
After	tlon: To	27. Manner of Death 1 ⊠Natural 5 □ Pending	28b. Ti	patient 3 C ime of jury	OA Other: 4 [28c. Injury at Work? 1 ☐ Yes			dence 6 □Other (Specify) how injury occurred			
volue nospies of Alestin within 24 hours after death. To the Funaral Director: A completely filled in by the fo	Certification:	a Could not be								r or Rural Route Number,	
n 24 hour n 24 hour ne Funar sletely fill.	Medical	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and	death occurre Vor investigation	d at the time, dat in, in my opinion,	te and place, death occurr	and due to the cau red at the time, dat	use(s) and mar te and place, a	nner as stated. nd due to the cause(s)	
To the To the comp	Ň	29b. Signature and title of certifier	Hess-8	Lugno	2nus 2	9c. License num D2807		29		(Month, Day, Year) .2, 2006	
5		30. Name and address of person who confirme Higgs-Si	nipman, M.	ath (Item 23a) (T	Type, Print) 00 Be1t	sville	Dr., B	eltsvill	e, MD	20705	
Sta Registi		31. Date filed (Month, Day, Year) JUN 1 6 20	32. Flogistrar	's Signature	Cooch	5					

		For State	State of Maryland /	Department of I		Mental Hyg	giene 2006	1902
A A		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
Physicia: /Medica		PAMELA	MICHEL	IE BRIS	SETT	Month	13 2006	1723 M
Examine		4a. Facility Name (If not institution, give	street and number)		or Location of Death		4c. County of Death	1
		5. Social Security Number 6. Se	lary and		moreo If Under 24 Hrs.	0 Data -(Bir	N	1A
Funeral Director		, , ,	x 7. Age (In yrs. last b)	Yrs. Months Days		8. Date of Birt (Month, Day		lace (State or Foreign htry) RVLAWN
land	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location			1	0d. Inside City Limits
deeth with the Maryland rms 23e or 28e-f show rmust be notified at	ō	MARVIAUN A	1/4	BA	LTIMOR	ECI	TV	1 Yes 2 □ No
ith the	Funeral Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What Cour	ntry?
a 23a	ē	3443 CLIFT	YONT AVENUE	=	212	13	USA	•
tter de	5	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No	13. Was Decedent of If Yes, specify Cub	ban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
5-UU36 72 hours af	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 🗷 No	Specify:		Specify: BL	ACK
ING 21215-UU36 be filed within 72 hours after deeth with the Marylan tal Hygiene. d other then "natural", or tiems 23s or 28s-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		a. Decedent's Usual Occu (Give kind of work done	during most of work	king	16b. Kind of Business/In	dustry
within ene.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	REIAI	1 PEDA	730	ATAT	
Hygi other	Se C	17. Father's Name (First, Middle, Last)	7/2 4/3	NEZHY	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
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_ 5 # 6 =	1	20a. Method of Disposition	EN MOTHER 20b. Place	of Disposition (Name of	HOLLY	ST. L	20c, Location - City or To	2/2d/
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🗖 교투원증 📗	1	21. Signature of Funeral Service Licens		22. Name and Addre	ess of Facility	30000	NOODLAW!	bal Hami
Depariming the many lr.		> XX you	on	3998N	PULTO	NAVE	JR. FUNE	40.21217
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do ne cause on each line.	not enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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fficate the pass the b	dical		d					
BOX 6 Beath certific ettending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	iry
The cords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the ettending physicien end bage 2 should be detached for use as the buriel-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	y 		Month	Day Year
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S offer of in the state of in	Certification:	4 Homicide	building, etc. (Specify)			City or Tow	n, State)	
		(Check only 2 Medical Exami	sician: To the best of my knowledg	e death accurred at the tr	me date and place	and due to the o	auca(c) and manner ac et	alled.
thin 2 the 1 mplet	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens			29d. Date signed (Month,	
F 8 F 8		^ :	MD //	I	76435515		6/13/06	Jay, rear
1	-	30. Name and address of person who co		(Type, Print)	T67 77377	600	0, 7,00	-
		Nich Sadegh		ity of M	laryland			
State	-	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
Registra DHMH 17 Rev 1/200		JUN 1 6 20	06 Brown Dr	treet)				
17 1147 17200			OI	RIGINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Bradford Mac 12:20 AM June 4, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Augs Lutheran Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2X F Yrs. 88 **Director** 298-24-5897 12, 1918 Georgia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23e or 28e-f show Examinar must be notified at 1 ☐ Yes 2 🕅 No Be Completed by Funeral Director Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mantal Hygiene. Sans it if item 27 is marked other than "naturel", or Items 23, and other freumatic event, the Marical Exam net must up or other freumatic event, the Marical Exam net must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes 2፟No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Oscar Dobbs Eddie Mae Glanton ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Milford Mill Rd., Pikesville, MD 21208 Rev. Gene C. Bradford (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Highland Park Cemetery 6/10/06 Highland Hills, OH 21. Signature Funeral Service Deenses 22. Name and Address of Facility
F.F. Boyd & Son Funeral Home mein 2165 E. 89th St., Cleveland, OH 44106 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Acute Cerebral Vascular Accident /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cerebral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ormed? 2 X No certificate Division of Vital 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 X Natural 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 THomicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 5,2006 JUNE 30. Name and address of person com leted cause of death (Item 23a) (Type, Print) 25 Main St., Reisterstown, MD 21136 Jef Ribell, MD 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Dieses to fresh Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		Please 1 - For State Registrar	State of Mar	yland / De	partmer		n and N	Mental Hy		17112	19025
		Negistrar Necedent's Name (First, Middle, La	act)			0 0, 000.	.,,	2. Date of Dea			3. Time of Death
Physic		J Am Es		ARKS DAL	E			Month JUNE	Day	Year 2006	945 A M
/Medi Exami		4a. Facility Name (If not institution, given	ve street and number)		4b. City,	Town, or Location	on of Death		4c. C	ounty of Death	
Exami	101	NORTHWEST 1	tospitAL		F	CANPALLS	To ~			BALT, MO	RE
Funeral		5. Social Security Number 6.	Sex 7. Age	In yrs. last birthda	y) If Under	r 1 Year If Und	der 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
Director		214-54-7333	1₫M 2□F	56 Yrs.	Months	Days Hour	rs Min.	(Month, Da July 16			intry) RYLAND
		Usual Residence of Decedent						oury ro			
ylan		10a. State 10b. County		IOc. City, Town or	Location						10d. Inside City Limits
Mar Mar	to	MARYLAND BALTI	MORE		BALTI	MORE					1 ∐Yes 2 ŽNo
r 28g	<u>re</u>	10e. Street and Number		-	10f. Zip	Code			10g. Citize	en of What Co	untry?
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deat	Jer	11. Marital Status	12. Was Decedent Ev	er in U.S. 1	3. Was Dece	dent of Hispanic	Origin? (Sr	pecify Yes or No	- 14	. Race - Amer	
affer a	Ē	1 Never Married 2 Married	Armed Forces?			cify Cuban, Mexi		Hican, etc.)		Black, White	, etc.
urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 No Spec	cify:		5	Specify: BI	ACK
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id be fill fental H rked off	ToE	ELIJAH J. BARKS	DALE				PEGGY	B BARKS	DALE		
Idf yidfild Z IZ 13-0030 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other then "naturel", or flems 23a or 28a-f show aumatic event, the Medical Expunition and the natified at		19a. Informant's Name/Relationship		19b. Ma	ailing Address	s (Street and Nu	mber or Ru	ral Route Numbe	er, City or	Town, State, Z	ip Code)
March 27 in tra	1	Sarah Stevens/S	ister	38	05 FOR	DLEIGH I	RD., 1	Baltimor	e, Ma	aryland	21215
Strain and a strai		20a. Method of Disposition		20b. Place of Dis	sposition (Na	me of		Date	20c. Loc	ation - City or T	Town, State
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ION OI VITAI nding Physicien: th. : After this certifice i funeral director, p	on:	27. Manner of Death 1 △Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	ry	28c. Injury at Work?		28d. Describe I	now injury	occurred	
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				epartment of Health and M Certificate of Death	1ental Hygie	2000	19027						
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death						
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	ar) Count	ace (State or Foreign						
L.	Director		Usual Residence of Decedent	rs.	OCT 13	1921	^m PA						
	rryland how	_	10a. State 10b. County 10c. City, Town	•		10	d. Inside City Limits						
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5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at		15. Decedent's Education 16a.	Decedent's Usual Occupation	16b	. Kind of Business/Ind	ustry						
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3altimore,	permit. Pages Depertment of important; if i any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	ZumBrun	I KH & MO	V Co.						
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			23a. Part Lender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										
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Box	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 montbs? 1 ☐ Yes 2 ☐ M6 25b. Yes, official of plegnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	y Day Year						
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	requires that een signed b nould be deta	à	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		to use contribute to the	cause of death?						
Records,	~ Q 70	Completed			1 Yes								
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Division of Vital	ilcien: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2	No 1 □ Yes 2	: □ NO						
of V	Phys this al dii	၉	1 ☐ Yes 2 ☐ No Hospital: 1 I wrient 2 ☐ ER/Out			6 ☐Other (Specify)							
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	Hosp 24 hos Fune etely fi	Medical	29a. Certifier (Check only one) 1	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as sta and place, and due to t	ted. he cause(s)						
	To the within To the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, D	ay, Year)						
	1		Bruncheta M. D.	ZES 000	6	19/06.							
	20		30. Name and address of person who completed cause of death (Item 23a) (1		TO COS ON	, MD, 212	20						
	Sta	ite.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	O . WHUCH OLVE,		111111 212	39						
	Regist		HIN 1 6 2006 Parker #	and a second									

CHRISTINE

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Year Medical Examiner 0228 hrs TREY BRANCH June 14, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday 9 Birthplace (State of **Funeral** Foreign Months Davs Hours Director 216 08 9742 Country) MD 2 APR.19 1___M 1985 Usual Residence of Decedent 3 IIV 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show MD. BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 2713 E. CHASE STREET USA Funera 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, "natural", or items Examiner must be 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 XNo specify: Specify: BLACK ð Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Ealtimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 ho.
Department of Health and Mental Hygiene.
Important: If free 27 is marked other than "natingury or other traumatic server. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH LABORER CARWASH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DEON BUSH PATRICIA BRANCH ပ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA WILLIAMS (mother) 2713 E. CHASE ST. BALTO, MD. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 crematory or other place) Cremation 3 Removal from State PARK JUNE 19,2006 BALTIMORE,MD. KING MEM. Ponation 5 Other Specify. ature of Funeral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 11412 E PRESTON ST. BALTO MD Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medica Death a. Stab wound of chest and gunshot wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical UNPENDED AMENDED attending physician the burial certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery Was decedent pregnant in the 3 Ectopic pregnancy Year Day Fetal death use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ğ Records, P. 1 Yes 2 V No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: of Vital Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject was stabbed and shot FOUND Natural Division Yes 2 V No 5 Pending 24 hours after death. Funeral Director: the Jun 14, 2006 0151 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2745 Preston Street, Baltimore, MD (Specify) Local Street 4 / Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. June 14, 2006 30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Day Year) 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23a, Pt.1,25 per ME C856, 06/14/06dhb Registrer Registrer 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 17, 2006 Sally Α. Cravens :30 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Futurecare Chesapeake Arnold
If Under 1 Year | If Under 24 Hrs. | <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Director 213-34-2570 Usual Residence of Decedent Sept. 14,1936 Illinois 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "neturel", or Itema 23s or 28s-f ehow the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 631 Laurel Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City N/ATelephone Operator 10 and Mental Hygi or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be W. Verlie Sexton Harold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre Deborah A. Tolomeo (Niece) 9252 Lost Fields Ct. Bristow Virginia 21036 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4/21/06 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) Lorraine Park Cem 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Faneral Service Licensee Approximate Interval Between Onset and Death 23a. Paul. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Staphylococc Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e re CERTIFICATION APPROVED LY VEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy been signed by the attershould be detached for Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 No 1 Yes Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes -3 SIL o within 24 hours after death.
To the Funerel Director: After thi
completely filled in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 30 Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) JUN 1 4 2006 State Registrar

Amend item#24a, perVerbal, 036,6/21/06 The State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 15 2006 06 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** A Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** Months Hours 1 M 2 □ F Yrs Director Usual Besidence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a.4 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3614 Woodb Ave 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) benter Itreumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumatic events. Lavern 000 ပ harles Der 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.) 2305 lar 406 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ F

4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Green mount -17-2006 21. Signature of Funeral Service Licenses ervice P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseq **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 1 Yes 2 X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 1 Yes 2 10 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After ! 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospitel within 24 hours a To the Funeral D Hospitel Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of o 29d. Date signed (Month, Day, Year) Name and add d cause of death (Item 23a) (Type, Print) gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** 06:00a 06-13-2006 Lois A. Chambers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ XF Yrs Ohio 06-06-1932 74 288-28-5373 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Silver Spring 1 Tyes 2XXNo MDMontgomery Funeral Director 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number 20910 USA 9101 2nd Ave filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Administrative Clerk C.I.A. 12 permit. Pages 1 and 2 should be tilk Depertment of Health and Mental Hy importent: If Item 27 ie marked othe any Injury or other treumsting. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mae Miller Arlie Chambers ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 M St. SW Washington DC 20024 Rev. John Talbott/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Slate Beltsville, MD Chesapeake Crematory 06-15-2006 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Servies
933 Gist Ave Silver Spring MD 20910 ma1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Failure Immediate Cause (Final disease or condition resulting in death) Days Physician /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physicien end detached for use as the burial-transit executed Nicotine Abuse Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. 9 Unknown certificate hes been signed irector, page 2 should be del Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🔯 No 1 ☐ Yes Hospital or Attending Physician: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 🖾 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: Al completely filled in by the fu 2 Accident investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD32332 06-13-2006 ma Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.K. Gupta 9801 Georgia Ave Silver Spring MD 20902 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUN 1 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 921 Month 2000 June Barbara Ann Crouse 4a. Facility Name. (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death AIR Health and Rehab Center BeLAIR Harford If Under 1 Year If Under 24 Hrs.
Months Days House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2% F 212-88-6022 Dec. 25,1964 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 Vale Road 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Colfege (1-4or 5+) Elementary/Secondary (0-12) Never Worked Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Lillie Whitaker Wade Tyre Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth L. Crouse / Mother 1109 Vale Rd., Bel Air, Maryland ace of Disposition (Name of 20c.) 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gard 6-15-06 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licensee

Mc Omas Funeral Home, P.A.

50 West Broadway, Bel Air, Maryland 21014

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Cause (Single) Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

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27 is marked other than "natural", or Items 23s or 28s-f show traumatic syant, its Medical Examinar must be notified at

al Hygiene.

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72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

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Records,

Division of Vital

attending physician and for use as the burial-transit Physician/Medical ned by the a certificate has been signed irector, page 2 should be de δ Completed funeral director, After this Certification: death. f or Attand efter death Director: /

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. We autopsy findings available for to completion of cause of death?

1 Yes 2/2 No 24a. Was an 1 ☐ Yes 2 2 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nersing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2€No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

filled in by

Medical

31. Date filed (Month, Day, Year)

To the Hospital of within 24 hours of To the Funeral D completely lilled in

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician Year MELVIN COATES JUNE PM 2006 8:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year tf Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 3, 1936 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland Funeral 1 M 2 □ F 216-34-4023 Yrs Director Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28s-1 show traumatic event, the Modical Examinar moust be notified at 1 Yes 2 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 N. Ellamont Street 21216 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Black. 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 NA Custodian Goucher College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in nent of Health and Mental I shi: If item 27 is marked o Allen Joseph Coates Ruth Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Thornton daughter 1655 Kirkwood Road Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5 Department of Important: If any Injury or page. Mt. Zion Cemetery June 15, 2006 Lansdowne, Maryland 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funerat Service Licenses 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) HEMORRHAGIC CEREBROVASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ending physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has b performe 2 No 21X No 1 ☐ Yes o the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNaturat 2 ☐ Accident 5 Pending investigation 1 Yes 2 No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Directompletely filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) imue UMP# P19840 - M.D JUNE 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONNIE TENG, 22 SOUTH GREENE STREET BALTIMORE, MD 21201 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State

Registrar

JUN 1 6 2006

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Clara Chatmon June 10, 2006 0701 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secour Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-22-9631 1 ☐ M 2 🔀 F 82 Oct 22, 1923 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other then "naturel", or Items 23s or 28s-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other then "natural", or Itams 23s or 28s-1 show other traumatic event, the Middical Examplement the collision NA Baltimore 1 XYes 2 No Maryland Direct 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 2801 Rayner Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Black ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nannie (live in) Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked ofther yor other traumatic event, QMEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Vida Johnson Raymond R. Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Owens sister-in-law 1118 McKean Avenue Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 16, 2006 Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee Jones 638 N. Gilmor Street Baltimore, Maryland 21217 insul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) relia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Attending Physician: The law requires that the deeth certificate be executed use as the burial-transit that initiated events resulting in death) Last ed by the ettending physicien and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 mooths? 1 □ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown has been signed by to 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ner Ha 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform this certificete 1 ☐ Yes 22 No 1 Yes 2 No ieral Director: After this certific filled in by the funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certified Level up D0051897 G/18/04
who completed cause of death (Hem 23a) (Type, Print)
UD OCH 9055 Cherrolet Drive Ste / BU Ellioth City 2104 NIIDERA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 6 2006 JA RESS Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2006 **Physician** Eugene Joseph Caretti 1:05 P M June 12, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2 ∏ F Yrs 60 218-46-6850 June 16,1945 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r then "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at Carney 1 ☐ Yes 2 No Baltimore Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 2904 Aspen Hill Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Board of Education Elementary/Secondary (0-12) Colfege (1-4or 5+) 7 Years English Teacher Harford County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Item 27 is marked ott Be Philomena Cimaglia Joseph Caretti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Aspen Hill Road Carney, Maryland Jean D. Caretti (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If It eny injury or c 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 6/15/2006 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Caske 7922 Wise Ave. Dundalk, Maryland cu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D ath Immediate Cause (Final disease or condition resulting in death) dusdennl Physician met astatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been signi rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 2 No or Attending Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSpice 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death | Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours at To the Funerel D completely filled i Hospital 29a. Certifier t Certifying Physician: To the best of my knowledge, death accurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 125205 ted cause of (Item 23a) (Type, Print) 6701 N. Charles St. Bolto Md 2,208 5 Bing 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Course ! Registrar

State of Maryland / Department of Health and Mental Hygierie 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 JUNE 13, Physician Year 8:00p M /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner 3680 FOREST GARDEN AVE. GWYNN OAK BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 7-23-1925 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 → M 2 □ F VÍRGÍNIA Yrs. 80 Director 213-28-0808 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be politied at 1 Ves 2 □ No Director MD. BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3680 FOREST GARDEN AVE. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 ie marked other then "ne eny injury or other treumatic event, the Medic 2008. Elementary/Secondary (0-12) College (1-4or 5+) -0-SELF EMPLOYED TAVERN OWNER -6-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JUDGE J. CLAYBORNE OTELIA CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3680 FOREST GARDEN AVE. GWYNN OAK, MARYLAND 21207 DOROTHY CLAYBORNE (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Z 3 Pemoval from State DRUID RIDGE CEMETERY 620-2006 BALTIMORE, MARYLAND 4 Donation 5 Oyler (Specify) Service Licen ONATHAN D. HIBNERS, Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 wher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulfing in death) Onset and Death Physician minute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as i ettending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ō Day Month Year 4☐Pregnant at time of death 5 Other (specify) deteched 9 Unknown ste has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 🗀 Yes 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 220 No this certificate has 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours effer death. To the Funerel Director: After 1 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🔀 Cartifying Physician: To the best of my knowledge ideath operand at the time, date and place, and dualto the causo(e) and manner selected Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 1/2001

Registra

31. Date filed (Month, Day, Year)

JUN 1 6 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene) 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 12, 2006 June 4:00 Louise Curcio 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Essex Golden Tree Lane | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days 1 □ M 2 F Feb. 5,_ Yrs. 82 1924 N. Carolina 237-36-1032 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No Baltimore Essex Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number S.A. 21221 Golden Tree Lane 8819 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 ₩ No Specify Specify. White 3 XWidowed 4 ☐ Divorced 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Waitress Restaurant 7th. Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Pearl Woodley James Edward Haire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Rolfes/Daughter Drive Conowingo MD 21918 33 Grace Ann Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/16/2006 Baltimore Holly Hill Cemetery 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licenses 6224 Eastern Avenue Baltimore 21224 Approximate Interval Between Onset and Death oppolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Failure arrythmin - atrial Fibrillation 20 years ardice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinational be notified at once.

Baltimore, Maryland 21215-0036

Viva

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Examiner led by the ettending physicien and detached for use as the burial-tran Completed by Physician/Medical page 2 should be tor: After this certific the funeral director. Be Certification: To 24 hours after death.

Funerel Director: At

been signed by

certificate has

Physicien:

Hospital or Attending

2

23b. Was decedent pregnant in the past 12 months? ☐Yes 2121No

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death Natural

2 Accident 3 🗌 Suicide

4 - Homicide

29a. Certifier

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

autopsy performed? Yes 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 2 No 1 Yes

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Injury

Other: 4 Nursing Home

5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

MD

21236

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated 29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

determined

Baltimore

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602 Belair Road Dr. Michael Martin

State Registrar

Medical

completely

within 2

31. Date filed (Month, Day, Year) JUN 1 6 2006

		-	For State Registrar	State of Marylan	Cei	tificate of De	ath		g. No.	0 19038
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		Charles	D	Do	rsey		Month June	12. 200	M
	/Medic Examin		4a. Fecility Name (If not institution, give :	street and number)		4b. City, Town, or Loca	ation of Death	ounc	4c. County of De	
	Funeral Director		Anne Arunde1 Med 5. Social Security Number 6. Security 15		last birthday) Yrs.		Under 24 Hrs.	8. Date of Birth (Month, Day, March 21	9. B	Arunde1 irthplace (State or Foreign Country) Mary1and
			Usual Residence of Decedent	02					,	,
	nylan how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	e Ma	g	Maryland Anne Ar	undel Pa	sadena					1 ☐ Yes 2 ☐ No
	th th	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (· ·
	23e	al	8495 Mast Court			21122				S.A
36	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23e or 28e-f show event, the Modical Evantinative Indiation at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 № Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☑ No Sp	nic Origin? (Spec lexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
5-0036	ature	ed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupation	1 , , ,	1:	6b. Kind of Busines	
75	n "n "n"	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done during DO NOT use retired)	g most of workin	ng		
21218	y the	E	12	N/A	F	irefighter			Baltimor	e City
ğ	il Hygie other	Be C	17. Father's Name (First, Middle, Last)			18.	Mother's Name	(First, Middle, M	aiden Sumame)	
Maryland		To E	Charles		Dorsey		Lillia	n		Smith
ary	2 should and Men Is marke eumatic	Γ_2	19a. Informant's Name/Relationship (T)			ng Address (Street and I	Number or Rural	Route Number,	City or Town, State	Zip Code)
	# 4 3 G		Joseph R. Dorsey	(Son)	256	Lower Mago	thy Bea	ch Rd. S	Severna Pa	ark MD 21146
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place)			0c. Location - City of	
Ë	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 3 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		11e V.A. Ce	m 6/16	/06	Peormov41	le Maryland
를	artm orter inju		21. Signature of Fyneral Service Licens		22	2. Name and Address of	Facility			
ñ	Depariment Department on in once.		1 St. F. 6	llina	M	cCully-Poly 204 Mountai	yniak Fu	neral Ho	ome, P.A.	nd 21122
	-		23a. Part. Enter the disease, or complishock, or heart failure. List only o	ications that caused the deal	th. Do not ent	er the mode of dying, su	uch as cardiac or	respiratory arres	st,	Approximate Interval Between
٦	Physician		Immediate Cause (Final	Mr. according	Til					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consect Septics	uence of):	CHEN				
	Examiner			Sentics	MOEK					
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Winarn T	venet	Infectio	on			
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P.O. Box	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	that hed by deta	by PI	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause given in	Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	quires n n signe							1 🗆 Yes	s 2 ₽ No 3□1	Probably 4 Unknown
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o	Phys er this eral di	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time o	the second second		8d. Describe how		outy)
O	th. : After s funer	ţ	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		2 🗌 No			
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h		reet, factory, office	2	8f. Location (Stre	eet and Number or i	Rural Route Number,
á	after after Dire	Certification:	4 Homicide	building, etc. (Speci	fy)			City or Town,	State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		sician: To the best of my knowner: On the basis of examinating and manner stated.						
	To the within 2 To the complet	We w	29b. Signature and title of certifier	to an early of the control of the co		29c. License nui	mber	29	d. Date signed (Mo	nth, Day, Year)
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In	11	l i	30. Name and address of person who co	ompleted cause of death (Ite	m-23a) (Tvoe.	Print)				334
10	1/	l i	30. Name and address of person who c	1 1		1 0 1	- Anna	atis ili	0 2140	31
0	1 Sta	ate	H. JOHNY MD.	Anna Arando	(Med	1 0 1	Anna	potis ili	D Z140	31
0	Sta Registr		H. YOUNG MD.	Anna Arando	(Med	1 0 1	Anna	potisiu	0 7140	31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, D2006 June 2:45 P. M Helen Marcel Dunn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 4303 Arabia Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Make Child 2 3 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2XX 91 Baittimore 213-03-9420 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 4303 Arabia Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Protection Company Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Josephine Maggiore Carmello Bellistri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 Montebello Terrace Baltimore Maryland 21214 Joseph Patti/Guardian 20b. Place of Disposition (Name of cometery, crematory or other place)
Most Holy Redeemer 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/19/06 Baltimore Marvland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road E mestina Itaze Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 ₽ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 ☑ 100 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide t 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0027860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. Univ. Pkwy BAH CHRISTOPHER <en nou

State Registrar

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Directo

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Funeral

Director

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certificate

To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director, Exam

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Medical

31. Date filed (Month, Day, Year)
JUN 1 6 2006

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

32. Registrar's Signature

ORIGINAL

		101	artment of Health and Me		ene 200	6 1904
		Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
Physic		Jeffrey M. Gross	J	Month Tune	10 200	6 8:00 A M
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 1 4 − 8 4 − 4 3 5 5	Mantha Dave House Min	Date of Birth	9. B	irthplace (State or Foreign
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and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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2 should be filed within and Mental Hygiene. and Mental Hygiene. la marked other than aumatic avant, tra M	۳	Charles W. Gross Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural I		City or Town, State	, Zip Code)
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ges 1 and 2 should to Health and Men If item 27 is marks or other traumatic		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City	
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permit. Peges 1 and 2 Depertment of Health a Important: If itam 27 is any injury or other tra		21. Signature of Funeral Service Licensee Zanny B. Reese M 02 483	2 Name and Address of Facility Im. Reese & Sons 121 West St. Anna	Mortua	ry, P.A	401
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funsrel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, dat	e and place, and d	ue to the cause(s)
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2.		flyth J.O.	447494		6/13/	106
2		30. Name and address of person who completed cause of death (Item 23a) (Type Monique Y. LANGSTON, T. O.	Print)	. 1~~	A POCIS	MT
~ 	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			- /	
Regis			barle			

06-03870 Wanda Gailey

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cei	rtificate o	Death		_	Reg	No.	UU	b 1904
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Baltimore, permit. Pages I an Department of Hea Important: If ter		20a, Method of Disposition 1 X Burial 2 Cremation 3	Removal from Sta		Place of Dispos crematory or other			Date		20c. Location -	City or To	own, State
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Division of Vital Records, tal or Attending Physician: The law requir is after death all Director: After this certificate has been seled in by the funeral director, page 2 should the control of the con	اڃَ	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injur (Month, Day,Ye Jun 5, 2006	y ar)	28b. Time of It		njury at Work	IDriva		v injury occurred		
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	one) 2 Medical Examin	er: On the basis of exam	ination ai	nd/or investigat	ion, in my opin	ion, death oc	curred at the tir	me, date and	d place, and du	e to the c	cause(s)
- > - >	ž	29b. Signature and title of certifier	//				ense number			9d. Date signed	_	i, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 2 U U 6 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 **Physician** June 13, Rose K. Graziani 5:19 ΑM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2909 Davidsonville Road Anne Arundel Davidsonville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1940 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 💢 F Yrs. Director 579-52-5240 66 Pennsylvania Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene.
ent: If item 27 is marked other than "natural; or items 23s or 28s-f ehov ury or other traumatic event, I'ra Medical Examinar must be notified at Director XXYes 2 □ No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 Davidsonville Road 21035 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Accounting William Cohen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irene Marie Bardo John Joseph Graziani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Tate/ Sister 1501 Southwest 17th Street Boca Raton, FL 33486 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 06/17/2006 Memorial Gardens Davidsonville, MD 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** Meriosclerost /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): physiclen Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 3/DProbably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec autopsy perform certificete 2.0 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient After this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ⊠Natural 2 ☐ Accident 5 Pending death. Director: / investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or the Funerel Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

1 sale

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 27 per Dr., C856,06/16/06db ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** 28ay 2006 J. IR. 2:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 5808 Parkway Drive Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 26, 1950) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Massachussetts 5. Social Security Number 6 Sex **Funeral** 187M 2∏ F Yrs May 26, 56 Director 013-40-5626 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Madical Exercines must be notified at 1 Yes 2 No Director Prince Georges Maryland Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 5808 Parkway Drive United States America 238 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. natural', or iteme 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Infortant: if Item 27 is marked other than "natural; or ite way lajury or other treumatic event, the Marcial Exertina and. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter J. Gray Sr. Amelia Stonis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stewart/Friend 5808 Parkway Drive Laurel Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ivy Hill Cemetery 6/1/2006 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd Laurel MD 20707 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Human Immunodeficiency Virus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🖄 No 2 □ No 1 Yes 1 Tyes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after determined 4 T Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE ST, BALTIMORT, MD 21205 GEETANJALI CHANDER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Beer . JUN 1 6 2006 Registrar

			1 - For State Registrar	State of	Marylar		artment of F tificate of		Mental Hy	giene Reg. No. 2)6	19045
	Physici /Medic		Decedent's Name (First, Middle, Li RONALD	ast)	G	SNIAZD	OWSKI		2. Date of De Month JUNE	_	Year 6	3. Time of Death 1:20 p M
	Examir	ner	4a. Fecility Name (If not institution, gi 940 S. LAKEW	OOD AVE	ENUE		BALT	r Location of Dea			Death	
E	Funeral Director		5. Social Security Number 218-36-0072 Usuel Residence of Decedent	Sex X M 2□F		last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		20, 1941		Nace (State or Foreign NYLAND
	death with the Maryland me 23a or 28a-f ehow I must be notified at	Director	10a. State 10b. County N/	А	10c. Ci	BALTI					1	0d. Inside City Limits 1X Yes 2 □ No
	23a or 2:	rai Dire	10e. Street and Number 940 S. LAKEW	OOD AVE	ENUE		10f. Zip Code	224		10g. Citizen of W	hat Cour	•
0000	or the	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2]K] No e	'	Vas Decedent of H f Yes, specify Cuba I □ Yes 🏖 No		Specify Yes or No to Rican, etc.)		- Americ , White, WH	
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ylana 4	d 2 should be filed to and Mentel Hygle 7 is marked other treumatic event, it	To Be C	17. Father's Name (First, Middle, Las	o DOWSKI				HELE	NA SU	n Maiden Sumame RZAN)	
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altimo	permit. Pages Depertment of Important: If it eny injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	ity)	tate	YVIEW	CREMAT(ORY 6/1			ORE,	MARYLANI
4	Physician /Medical Examiner	Examiner	23a. Pant1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (6	or as a consecutive as	th. Do not ent	er the mode of dying Infan	g, such as cardia	c or respiratory a	ALTIMOR.	e, MI	Approximate Interval Between Onset and Death
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VII	ysician: is certifice director, p	To Be C	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2] ER/Outpatien	3 DOA Oth		ath (Check only o			
Vision of	To the Hospitel or Attending Physician: The I within 24 hours effet deeth. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not leads	on De Do	n, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe	how injury occurre	d	
2	ospitel or A hours efter unerei Dire		4 Homicide determined	buildin	g, etc. (Special	fy)	occurred at the tim	ne, date and place	City or Too	wn, State)		
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manni	er stated.	ation and/or inv	29c. Licenso		irred at the time,	date and place, ar		
	3		30. Name and address of person who	www Pa	AC	3509	Print) Eastern	Ave. B	altim	ure, MD.	217	224
	Sta		31. Date filed (Month, Pay, Year)	2006 32.	gistrar's Signa	alura	7-10-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:00 A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SECOURS tos MORE 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 246-62-1300 Usual Residence of Decedent Months Min 1 ☐ M 2 🗓 F Days Hours Director North arolina filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be motified at 10d. Inside City Limits 1 Yes 2 □ No Director Maryland nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 d Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify Completed by 3 ☐ Widowed 4 ☑ Divorced Bla Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 2 echnician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ၉ aeD Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 IVIS, lamm 20b. Place of Disposition (Name of 20a. Method of Disposition Date or other place. ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If 200 ar Injury 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service/Licensee any Ir Home, P.A. oseph uneral North Ave. Balto. 2222 Md. 2121 W Enter the disease, or complications that, or heart failure. List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physicien pege 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 DUMKnown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No 1 Yes neral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Medical Certification; To 2010 1 atient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the h 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar KOSI

31. Date filed (Month, Day, Year)

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completed cause of death (Item 234) (Type, Print)

202000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1^{Day} Month 06 2006 Raymond Wallace Harwell 5:40am M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Gaithersburg Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08-05-1922 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number Days Min XXM 2□F 238-44-1438 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Wheaton Montgomery 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3312 Floral St. 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ŽYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 🔼 No Specify: Specify: 3 ☐ Widowed 4 P Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) US Government Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lester Harwell Ella Lynch Harwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Floral St. Wheaton MD 20902 Elizabeth Mary Klipple/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06-17-2006 Smithberg Cemetery Smithberg, MD 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 m3135 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 Inpatient 2 □ EP/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of card completed cause of death (Item 23a) (Type, Print)
-SAYYAD 9715 Mc Centa D. JUN 16 2006

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Director

by Funeral

Completed

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturat", or items 23e or 28e-1 show any Injury or other treumatic event, the Medical Examinar must be notified at once.

Physician

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

death.

within 24 hours a
To the Funersi C
completely filled

Division of Vital Records, P.O. Box 68760.

/Medical Examiner

> the attending physicien and hed for use as the burial-trans

sers! Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached.

Examiner

Physician/Medical

Completed by

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Certification; To

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3altimore, Maryland 21215-0036

		1	For State Registrer	State of Maryland / De	partm	nent of H	ealth and M	lental Hygi	ene? (g. No.	06	19048
	Physicia		Decedent's Name (First, Middle, Last)	HARRY EUGENE F	IUNDE	ERTMARK		2. Date of Death Month	Day	Year 2006	3. Time of Death 550 pM
	/Medic Examina Funeral	er	Sinal Lospita. Social Security Number 6. Sex	7. Age (In yrs. last birthd	(ay) If U	City, Town, or A LIN	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 23	N/A	9. Birthpla Count	ace (State or Foreign
	Director Motol Motol	or	217-14-2186 Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town o			ltimore	Apr 23	, 1923		7 land Od. tnside City Limits 1X Yes 2 □ No
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	uld be filed Mental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) John	Albert Hundertma	ark		18. Mother's Nam Ada			name)	
, Maryland	and 2 shou alth and M 27 ie mar er treumat		19a. Informant's Name/Relationship (Type Russell Crocetti	(Nephew) 11	LO2 K	Krueger	Ave., Ba	altimore,	Md.	21237	
Baltimore,	t. Page: rtment o rtant: If njury or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service License	moval from State Cedar I	cremator 1i11	or other place Cemete	ry 6/15	5/06	Balti	•	Maryland
Bal	Depermitment of the permitment		1/2		YK I	Cully- BO E. F	Polyniak ort Ave.,	Funeral Balto.,	Home,	P. 212	30 Approximate
,09/	Physician /Medical Examiner sicieu and phrial-transit	sai Examiner	23a. Part 1. Enter the disease, or complic shock, or heart tailure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	A,	y the	W 1 &	o toppiatory and			Interval Between Onset and Death
P.O. Box 687	Attanding Physicien: The law requires that the death certificate robath. stor: After this certificete has been signed by the ettending physby the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		opic pregnancy ner (specify)	,		23d.	Date of delive Month	ery Day Year
	uires that the de signed by the lid be detached	þ	Part II. Other significant conditions con	tributing to death but not resulting in t	the under	lying cause gr	ven in Part I.				he cause of death?
Division of Vital Records,	The law require ste hes been sl page 2 should l	Completed						24a. Was a autops perfor 1 Yes	med?	4b. Were auto prior to co death? 1 \(\sum Yes	psy tindings available mpletion of cause of 2 100
Vita	icien: certific rector.	Be	25. Was case reterred to medicat examiner? 1 □ es 2 □ No	lospitat: 1 ☐ Inpatient 2 ☑ ER/Out	nationt '	3□ DOA Ott	200	th (Check only on lome 5 ☐ Reside		Other (Specif	(v)
on of	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti	me of jury	28c. Inju Wo		28d. Describe h			
Divisi	of or Attention of a state of a state of the	Certification:	3 Suicide 6 Could not be determined	28e. Place of trijury - At home, tare building, etc. (Specify)	m, street,	factory, office		28t. Location (S City or Town	treet and N n, State)	umber or Rura	al Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 Certifying Physical Exemi	sicien: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death oc Vor invest	tigation, in my	opinion, death occu	irred at the time, d	late and pla	ace, and due t	o the cause(s)
	To the To the Comp	2	29b. Signature and title of certifier	& M.D.		29c. Licen	54482		Ju	igned (Month,	2,2006 121215
_	6		Patrick McGi		Type, Prin	st Bel	vodera 1	Ave Ba	Itimo.	e, MI	121215
	S	tate	31. Date tited (Month, Day, Year)	32. Registrar's Signature	4						

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ORIGINAL

4b. City, Town, or Location of Death

4c. County of Death

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow eny injury or other traumatic event, Ita Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director: page 2 should be detached for use as the burial-transit

	Riderwood V	/illa	ge			Silv	er S	pring	3		Me	ontgom	ery
	5. Social Security Number		Sex 1 □ M 2 🛣 F		rs. last birthday)	If Unde Months	Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	1 0	rthplace (State or Foreign country)
	370-26-9618	3	1 □ M 2LΔF	99	Yrs.					May 10	, 190)7 Mic	chigan
	Usual Residence of Decede												T
1.	10a. State 10b. C	ounty		10c.	City, Town or L	ocation							10d. Inside City Limits
101	Florida Pa	sco		Ze	ephyrhil	1s							1 ZYes 2 ☐ No
Fe	10e. Street and Number					10f. Zi	p Code				10g. Citiz	en of What C	country?
0	5625 Mandan	Stree	t			3:	3541				U.S	.A.	
Jer	11. Marital Status		12. Was Dec	edent Ever i	n U.S. 13.	Was Dece	edent of H	ispanic O	rigin? (Spe	ecify Yes or No Rican, etc.))- 1·		erican Indian,
교	1 Never Married 2	Married	Armed Fo	2 🚰 No	- 1					Rican, etc.)		Black, Wh	
þ	3 🖾 Widowed 4 □ Div	rorced	If Yes, Gi	ve lates:		1 🗆 Yes	2 [™] No	Specify	<i>!</i> :		3	Specify: Wh	nite
To Be Completed by Funeral Director	15. De	cedent's E	ducation		16a. Dece	dent's Usi	ual Occup	ation	st of work		16b. Kin	d of Busines:	s/Industry
pe	Elementary/Secondary (0		ade completed) College (life.	DO NOT	use retire	duning mo d)	St Of WORK	ing			
Ю	, .	,	3 ``		Regi	ster	Nurs	se			Но	spital	
ě	17. Father's Name (First, M	liddle, Lasi	1)					18. Moth	er's Name	First, Middle	, Maiden S	Sumame)	
.o	Abram Under	wood						Edi	th Pa	ayne			
-	19a. Informant's Name/Rel	ationship ((Type, Print)		19b. Maili	ng Addres	s (Street	and Numb	per or Rura	al Route Numb	er, City or	Town, State,	Zip Code)
	Troy B. Unb	an	(Gra	ndson)) 10 Co	untr	y Roa	ad 35	60 F	Lora Vi	sta,	NM 874	15
	20a. Method of Disposition				b. Place of Disp	osition (Na	me of	T		Date			r Town, State
	1 XBurial 2 □ Crem 4 □ Donation 5 □ Ot			State	cemetery, cre Carson C				6/17/	/06	Cars	on Cit	v. MT
	21. Signature of Funeral Se					2. Name a	_				ourb	011 011	.,,
	<u> </u>	- /2-	I for	-		Osco	od Fu	mera	1 Hon	ne	3.FT /	20.70	
	23a. Part1. Enter the disea		When	nausad tha d	toath Do not on					Johns,		00/9	Approximate
	shock, or heart failure	E. List only	one cause on	each line.	Jeans, Do not en	ter the tho	de or dyn	ig, such a	s calulac (л тезрітатоту а	mest,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition		a Pano	creati	c Carci	noma							
	resulting in death)	•	Due to	(or as a con	sequence of);								
	Sequentially list conditions		b										
ne	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	• 』	Due to	(or as a con	sequence of):								
am	that initiated events resulting in death) Last	1	c										
ũ	resulting in dealing cast		Due to	(or as a con	sequence of):								
by Physician/Medical Examiner		•	d										
Med	IF FEMALE:		"				-						I.
an	23b. Was decedent pregna in the past 12 months			birth 2 🗆 F	Fetal death 3]Ectopic p	oregnancy	,			23	3d. Date of de Month	elivery Day Year
S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregi 9⊟ Unkn	nant at time	of death 5	Other (s	pecify) _				and the same of th	771011111	July 7.001
Phy										an Did			
þ	Part II. Other significant co	onditions	contributing to d	eath but not	resulting in the L	inderlying	cause giv	en in Part	l.				to the cause of death?
ted			-								Yes 212	1N0 3 F	robably 4 Unknown
pe										24a. Was		24b. Were a	utopsy findings available completion of cause of
Completed										perfo	rmed? 2X No	death? 1 ☐ Ye	_
0	25. Was case referred to m	nedical						26. Plac	e of Death	h (Check only o			
To B	examiner?		Hospital: 1 🗆	Inpatient :	2 ER/Outpatie	nt 3 🗍 D	OA Oth	ег: 4 Ж N	lursing Ho	me 5 ☐ Resi	dence 6	Other (Sp.	ecify)
	27. Manner of Death		28a. Date	of Injury oth, Day Yea	r) 28b. Time o	of	28c. Injur Wor			28d. Describe			
atlo		Pending investigation		in, Day 7 oa	injury	М		Yes 2]No				
150		Could not be determined	4 28e. Place	e of Injury - A	At home, farm, st	reet, factor	ry, office					Number or F	Rural Route Number,
Certification:	- Intilicide		Build	ing, etc. (Sp	ouly)					City or To	····, Jiaie)		
al	29a. Certifier 1 Ce	rtifying P	hysician: To th	e best of my	knowledge, dea	h occurred	d at the tir	ne, date a	nd place,	and due to the	cause(s) a	and manner a	is stated.
Medical	(Check only 2 Me	odical Exa	miner: On the b	pasis of examiner stated.	nination and/or in	vestigation	n, in my o	pinion, de	ath occurr	ed at the time,	date and p	place, and du	e to the cause(s)
¥	29b. Signature and title of	certifier	1 1			29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
	1 HARA	1 /	White	W		D	0043	375			June	13,	2006
	30. Name and address of p	person who	completed cau	se of death	(Item 23a) (Tyne								
	Karen Merri		и. D.		Gracef		Rđ.	Silv	er S	nring.	MD 20	904	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		•	For Stata Registrar	State of M	Marylan	d / Depa <i>Cer</i>	irtme <i>tifica</i>	nt of H te of L	ealth and Death	Mental Hy	/giene Rag. No.		19050
	Physicia		Decedent's Name (First, Middle, Last James W. Hill)						2. Date of D Month	eath Day		3. Time of Death 8:29 A M
	/Medic Examin		4a. Facility Name (If not institution, give Holy Cross Hospi		r)				Location of Dea Spring		4c.	County of Deat	h
	Funeral Director		251-84-9845	x 7. /	Age (In yrs. 57	last birthday) Yrs.		er 1 Year Days	If Under 24 Hr. Hours Min		rth ay. Year) 7 49	9. Birt P1um	hplace (State or Foreign nuntry) Branch, SC
	death with the Maryland ims 23e or 28e-f show i must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgomes	·y		y. Town or Lo 1ver S		ıg					10d. Inside City Limits 1X∑Yes 2 ☐ No
	with the	I Direc	10e. Street and Number 2908 Chapel View	7 Drive			10f. Z	ip Code 20904			10g. Citi	zen of What Co	ountry?
0000	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itema 23e or 28e-f show entry injury or other traumatic event, the Mudical Examiner must be notified at any injury or other traumatic event, the Mudical Examiner must be notified at angle.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 [3]Yes 2 [If Yes, Give Year or Date:	s?] No	11	f Yes, sp	edent of Hi ecify Cuba 2\lefta No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, White Specify: B1a	e, etc.
N-C 7	within 72 hou ane. then "nature the Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	cation e completed) College (1-4c 2yr		life. L	kind of w OO NOT	ual Occupa rork done d use retired	furing most of we)	orking		nd of Business/	Industry
lang z	uld be filed Aental Hygie rked other tic event, It	To Be Co	17. Father's Name (First, Middle, Last)		5.	IRA	1211	POLI	18. Mother's Na	ame (First, Middle ice Will	e, Maiden	IATA Sumame)	
Mary	nd 2 shou alth and N 27 is ma or trauma		19a. Informant's Name/Relationship (7) Evelyn Hill/Wif			1		11.000		Rural Route Num Silver			
saitimore,	Peges 1 a nent of Hei ant: if Itam ary or othe		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		te C	Place of Dispo cemetery, cren	sition (N natory or Nat	ame of other place	e) 06-3	Date 19-06	20c. Lo	cation - City or	Town, State
Ball	permit. Departr importr eny inj		21. Signature of Funeral Service Licens	hall		22	. Name :	and Addres	s of Facility Ma	ershall' W. Wash	ingto		
•	Physician Medical Physician Physicia	I Examiner	23a. Part1. Enjer the disease, or comp shock, by heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardi Due to (or b. Myoca Due to (or	i line. Omy Op 8 as a conseq	uthy juence of): s juence of):			g, 2001 au 0a 0a				Approximate Interval Between Onset and Death
O. Box ba/bu	w requires thet the death certificate been signed by the ettending physic should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Feta	al death 3]Ectopic] Other (s	pregnancy specify)				23d. Date of del Month	ivery Day Year
7	The law requires thet are has been signed by bage 2 should be deta	ह	Part If. Other significant conditions on Thrombocytopen			ulting in the u	nderlying	cause give	en in Part I.				o the cause of death?
Vital Hecords,	The lar ate has page 2	Completed	Cardiomegaly -	Chronic						24a. Wa aut per X Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
<u></u>	ng Phy ter this neral d	on; To Be	27. Manner of Death 1. ☑ Natural 5 ☐ Pending	Hospital: 1 Inp. 28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury		28c. Injury Work	er: 4 □ Nursing ⁄at </td <td>Home 5 Res</td> <td>idence</td> <td></td> <td>cify)</td>	Home 5 Res	idence		cify)
Division	Attsn r deel ector	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At h etc. (Specii	ome, farm, str fy)	M eet, facto		Yes 2 □No	28f. Location City or To	(Street an own, State	d Number or Au)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	Medical	29a. Certifier 1 Certifying Phyone 2 Madical Exert	vsician: To the be iner: On the basi and manner	of examina	owledge, death ation and/or in	vestigatio	on, in my op	oinion, death occ	ee, and due to the curred at the time	, date and	place, and due	o to the cause(s)
	To the within To the compl	2	29b. Signature and title of certifier	elana	1			9c. License				te signed (Mont	ก, Day, Year)
4	,	ate	30. Name and address of person who or Richard P. Delan 31. Date filed (Month, Pay, Year)	ey, MD.	3929 strar's Signa	Ferran	a Di		lver Spi	ring, MD	. 209	906	
3.5	Regist		JUN 1 6 20		3. A.B 0 J	Or Say	and	F					

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10 m 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balhmore Maryland Medica 0+ University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠** M 2□ F Yrs. 215-18-770 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location -how of Health and Mental Hygiene. Item 27 is marked other than "nature!", or Items 23s or 28s-1 show other troumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Š 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DERVICE aborer GROOL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21215 W. Garrison lizabeth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its eny injury or ot 2000s. 1 ☑ Burial 2 ☐ Cremation 3 Removal from State and solvione, Mil 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
VAUGHA GLECK
SIST BAHO. Nat permit. 21. Signature of Funeral Service Licensee Funceal SVC GREENE Pike Baltimore, MD 21229 (-1 reen Vatl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meta police **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit MENO Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 4 Uhknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2□ No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death
Natural
2 Accident Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🔲 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide rigidertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29a. Certifier (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of	f Maryland	-	artment of H tificate of L			giene Reg. No.	200	6 1905
Physician		I. Decedent's Name (First, Middle, Last	Hudnall					2. Date of De Month	Day	Year 2006	3. Time of Death () 9 4 7 M
/Medical Examiner Funeral	5	ia. Facility Name (If not institution, give	street and nur			4b. City, Town, or 3 cc (Location of Death WOVE If Under 24 Hrs. Hours Min.	8. Date of Birn (Month, Da	4c. C	9. Birth	place (State or Foreign
Director wow	l	Jsual Residence of Decedent 10a. State 10b. County	J.W. SAL		Town or Lo	cation		07/31/1	950		yland 10d. Inside City Limits
th the Mary or 28a-f eh e notified	ļ	Maryland NA 10e. Street and Number			Baltin	ore 10f. Zip Code				en of What Cou	M∑Yes 2 No intry?
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mantal Hygiane. To fleath fraumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at To Be Completed by Funeral Director		2416 Loyola Northway 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		2 X No		21215 Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 25 No	spanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Black	, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft in and Mantal Hygians 77 is marked other than "natural," or traumatic event, the Madical Exercitional Property To Be Completed by F		15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired urity Guard	ation <i>luring</i> most of wor)	king		d of Business/I llins Ter	•
laryland 212 2 should be filed with and Mantal Hygiana and Mantal Hygiana aumatic event, Ital To Be Com	3	17. Father's Name (First, Middle, Last) Herman F. Jennings					18. Mother's Nan Pea	ne (First, Middle arline R.		Sumame)	
Mary and 2 shou aith and h 27 ie ma		19a. Informant's Name/Relationship (7 Pamela Jackson/ Daug			1209	ng Address (Street a Ashburton S	t. Balto.,N	1D 21216			
Baltimore, M Bernit, Pages 1 and 2 Department of Haalth my night or other tri and night or other tri		20a. Method of Disposition 1 Here of Disposition 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		State		sition (Name of matory or other place Lal Park	06/19	Date 9/06		ation - City or T allstown,	
Baltimor permit. Pages Deportment of I Importent: If its any injury or o		21. Signature of Funeral Service Licent	gon	e0	22	2. Name and Address	wy	/lie Funer Lto.,MO 21		me P.A.	4
Applysician and physician and the burial-transit in a burial-transit dical Examiner	200	23a. Part1. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	coras a consequence of the conse	Fair	lure lure	g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death 2 Yr5
s, P.O. Box 68 as that the death cartifice gened by the attending properties as the detached for use as the physician/Medican/) Sicial Simo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live t	tcome of pregnan birth 2 Petal on nant at time of dea own	death 3[_Ectopic pregnancy ☐ Other (specify)			2:	3d. Date of deli Month	very Day Year
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of Vital F hysicien: Th his cartificate il diractor, pag	ו ב	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2 DE	R/Outpatie	nt 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	ath <i>(Check only</i> Iome 5 ☐ Resi		☐Other (Spec	ıfy)
Division of Vitalital or Attending Physicien: s after death. al Director: Atter this cartificated in by the funeral director.		27. Manner of Death 1 ① Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		oth, Day Year)	28b. Time o Injury	M 1 □	y at k? Yes 2 □ No	28d. Describe			ral Route Number,
Divisic bital or Attendurs after death oral Director: Hed in by the		4 Homicide determined	build	ling, etc. (Specify)		reet, factory, office		City or To	wn, State)		
To the Hospital of within 24 hours at To the Funeral D complataly filled in Medical Con	Jedica Jedica	(Check only 2 Medical Exam	iner: On the b	e best of my know pasis of examination mer stated.	neage, deat on and/or in	h occurred at the tir evestigation, in my o	pinion, death occu	rred at the time,	date and	and manner as place, and due signed (Month	to the cause(s)
Son Son		29b. Signature and title of certifier	M/	7				7			
27		30. Name and address of person who	et, Do		35 U	Print) J. Belve	4315, dere	Bullin	nore,	MOT	21215
State Registra		31. Date filed (Month, Day, Year)		Registrar's Signatu	ITO .	also .			,		

			For State Registrar	State	of Marylai	nd / Depa		t of H	ealth a	and M		giene Reg. No.	006	19053	}
	9		1. Decedent's Name (First, Middle	, Last)							2. Date of De. Month	ath Day	Year A	3. Time of Death	
	Physicia /Medic		Gina L.	Hancock							06	14	2006	1055 A.M.	,
,	Examin		4a. Facility Name (If not institution	, give street and no	ımber)		4b. City,		Location of	of Death		4c. Co	unty of Death		
			Union Memorial		7 4 4	Contractor de la contra	If Under		imore If Under	24 Hrs	8. Date of Birt	•	NA NA	-1 (Ch.4	_
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2X☐ F		. last birthday) Yrs.	Months	Days	Hours	Min.	(Month, Da			place (Stete or Foreign ntry)	
Н	Director	-	217-84-2296 Usual Residence of Decedent		31						01/10/1	975	Mar	yland	
	yland Now		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits	
	B-f al	호	MD N	IA		Ba	ltimore	9						N⊠Yes 2 No	
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	ours after death with the Maryland "at", or Rema 23a or 28e-f ahow Exactiver must be notified at	aip	2642 Harford Rd.					L218				USA			
		Funeral	11. Marital Status	Armed F		J.S. 13.	Was Deced	ient of Hi	ispanic Ori In, Mexicar	igin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Bleck, White,		
9	hours after tural', or Ite	by Fu	1 X Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes If Yes, G Year or	2√1∑No live		1 🗆 Yes	2 / No	Specify:			Sp	ecity: Bla	ck	
3	일 등 등		15. Deceden		Dates.	16a, Dece	dent's Usua	d Occupa	ation			16b. Kind	of Business/In	ndustry	_
Ċ	filed within 72 Hygiene. other then "net ent, the Medici	Completed	(Specify only highes	t grade completed		(Give	kind of wor DO NOT us	rk done d se retired	during mos	t of work	ing			,	
25	than in	mo	Elementary/Secondary (0-12) 9 years	College	(1-4or 5+)	House	ewife					Dome	estic		
9	be filed within tal Hygiene. d other then event, the M	BeC	17. Father's Name (First, Middle,	Last)		,			18. Mothe	er's Name	(First, Middle,	Maiden Sui	mame)		
Maryland 21215-0036		To B	Preston Hancoo	k						Bertl	ha Purnel	.1		12	
ar)	s 1 and 2 should f Health and Men Itam 27 Is marke other traumatic		19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address	(Street a	an <i>d Numb</i> e	er or Rura	al Route Numbe	er, City or To	wn, State, Zi	o Code)	
	and and a n 27 n 27 ner tr		Lamont Matin / Fr	iend	Last	2642 1	larford	M.	Balto	MI	21218 Date			0	_
ore	Pages 1 nent of H int: if ital		20a. Method of Disposition 12 ◯ Burial 2 ◯ Cremation	3 □Removal from	State	Place of Dispo cemetery, crei	matory or o	ther plac					ion - City or T		
	men tmen tent:		4 Donation 5 Other (S		Ki	ng Memor:				06/16			lstown,	MD	-
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service	Licensee	\sim						ie Funera ,Md 21217		P.A.		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea									Approximate	-
			shock, or heart failure. List Immediate Cause (Finat	only one cause on	each line.	Sal	17:1	,	•					Interval Between n et and Death	
FK.	nysician /Medical		disease or condition resulting in death)	a	(or as a conse	C) COCCUCIO	4 60						- 0	XVA	4
	Examiner				1./.0	A LII	inter	hel	0					Laus	
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due t	(or as a conse	quence f):	o cree	100	4					2	Т
	cuted	Examiner	that initiated events	S	7/125	1								3 years	
,097	te be executed ysicien and te burial-transit		resulting in death) Last	Due to	o (or as a conse	quence of):								V	
976	# × #	icai		d											
x 68	entific ding p	/Mec	IF FEMALE:	230 If yes o	utcome of preg	nancy						004	Data of dalla		
Вох	ettenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	tal death 3	☐Ectopic pr☐Other (sp		1			230	. Date of deliv Month	Day Year	
P.O.	uires that the de signed by the e Id be detached f	by Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk				,,							Ų
م	that	Y P	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	inderlying c	ause giv	en in Part I	l.	23e. Did t	obacco use	contribute to	the cause of death?	
rds	w requires been sig should b										1 🗆	Yes 2	io 3□Pro	babty 4 Unknown	
၀	aw re	Completed									24a. Was	an 2	4b. Were aut	opsy findings available empletion of cause of	
m m	The I	E										No No	death?	2□ No	
İta	ilan: ortifica ctor,	Be	25. Was case referred to medica examiner?							e of Deat	h (Check only o				-
<u>></u>	hysic his ce il dire	ပ္	1 ☐ Yes 2 D No			ER/Outpatie		_	4 🗀 140		me 5 Resi			fy)	_
Ĕ	ing P	lon:	27. Manner of Death 1 Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time o tnitury	of M	28c. Injun Wor	yat k? Yes 2. □		28d. Describe	how injury o	ccurred		
isic	ttend death stor: /	Icat	2 Accident investi	not be also Bla	ce of Injury - At	home larm et			165 2	1140	28f Location (Street and N	lumber or Ru	al Route Number,	
Division of Vital Records,	Hospital or Attanding Physician: The law requires that the death certifica 24 hours after death. Funeral Director: After this certificate has been signed by the ettending phone in the funeral director, page 2 should be detached for use as the filled in by the funeral director, page 2 should be detached for use as it.	Certification:	4 Homicide determ	nined 200. I la	ding, etc. (Spec	cify)	1001, 120101	y, omoo			City or To				
	spita nours nerai		29a. Certifier Certifyin	ng Physician: To t	he best of my ki	nowledge, deal	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) an	d manner as	stated.	_
	To the Hospital or Attending Physician: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examination of the state of the sta	nation and/or in	vestigation	, in my o	pinion, dea	ath occur	red at the time,	uate and pla			
	To the within 2 To the comple	Σ	29b. Signature and title of certific	Lasha			290	C. Licens	e number	07		29d. Date s	igned (Month,	Day, Year)	
)			·ww//	110111	a MO		X	100	17/	0		JV	re /-	1,0006	
1	, 1		30. Name and address of person	who completed ca	use of death (tr	23a) (Type	Print)	DIF	= 1)0	Yeur	to Aku	14 B	altino	10 21218	
	C+	ate	31, Date filed (Month, Day, Year,	32.	Registrar's Sig	nature	7 10	010		,	1	Ji -			
	Regist		JUN 1	3 2006	Delies.	Si A	seeds)	9			Ay Aku				
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06-03981 Tedd Hart

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

aa nan		State of ivialylar - For State degistrar		tificate of Deat			g No. 200	6 1905
Physicia	n/	Decedent's Name (First, Middle,Last)		TI- 10+		Date of Deat Month	h Day Year	3. Time of Death 0931 hrs
edical Examir		Tedd 4a. Facility Name (if not institution, give street and num	nber)	Hart 4b. City,	Town, or Location of Dea	June 10, 2	4c. County of Dea	
		Upper Chesapeake Hospital			r, Maryland		Harford	
Funeral Director		218-64-2588 1XM 2F	7. Age (In yrs. la	st birthday) If Und Yrs.	er 1 Year If Under 24H ns Days Hours M		h(MM/DD/YYYY) 9. B Fore 5,1956	
any	1-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d Inside City Limits
ind show a	اۃ	PA York		I	elta			1 Yes 2 X No
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number	•	10f. Zip			g. Citizen of What Co	
ith the 23a or notifie		211 Forest View Drive	dent Ever in U.S	S 13 Was Decede	17314 ent of Hispanic Origin? (United St	ates erican Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed For 1 Yes			fy Cuban, Mexican, Puer		White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:			X No specify:		Specify:	White
hours "natur	ted	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-			Occupation (Give kind or rking life, DO NOT use re		16b. Kind of Business	s/Industry
036 ithin 72 ne r than Iedical	Completed	2 Year	·	Mecha	inic		Contrac	ting
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)			18.Mother's Nar	ne (First, Middle, N	Maiden Surname) • Everetts	
2127 ald be a Mental marke	o Be	Otto D. Hart, Sr. 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address	s (Street and Number o			
MD and 2 shoulth and m 27 is aumativ		Mrs. Evon E. Hart (Wife			est View Dri			
ore, land of Heal of H		20a. Method of Disposition 1 Burial 2 Y Cremation 3 Removal fro		Place of Disposition (Na crematory or other place)	Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages 1 ar Department of He. Important: If ite		4 Denation 5 Other Specify: 21. It sture of Funeral Service Lice i.e.	Hi	lltop Servi		5/15/2006		Maryland —
Bal permi Depar Impo	Į	Magon E. Ker			Address of Facility Ruck Funeral Vise Ave. D			Inc. 21222
Physician	7	23a. Part I. Pyter the disease, or complications that ca failure List only one cause on each line	used the death.	Do not enter the mode	of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Narcotic Due to (br as a death)			and cocaine u	se		Death
- Jan		Sequentially list conditions, b.	consequence of). 				
	iner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause c.	consequence of	f):				
_ 4×	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a	consequence of	f) ⁻				
xecute n and l - tran		d. AMENDED AMENDED	item#23a.	27.28a-f.perM	E,g857,7/5/06		 	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical		utcome of pregr				23d Date of delive	эгу
687 certificanding p	/sician/	23b. Was decedent pregnant in the past 12 months?	rth ant at time of de	2 Fetal death		nancy	Month	Day Year
Box 687 e death certific the attending p ed for use as th	ysic	1 Yes 2 No 9 Unknown 9 Unknown		ath 5 Other (Spe	ecity)			
P.O. I	by Phy	Part II. Other significant conditions contributing to	death but not re	esulting in the underlyin	g cause given in Part I.		bacco use contribute t	o the cause of death? obably 4 🗸 Unknown
rds, P.C requires that been signed						24a. Was a		autopsy findings available
COFC	Completed					autop perfor	sy prior to med? death?	completion of cause of
Vital Rec ysician: The his certificate		25 Was case referred to medical			26.Place of Death (Chec	1 Yes :	2 No 1 🗸	Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been s led in by the funeral director, page 2 should t	o Be	examiner? 1 Ves 2 No Hospital: 1 Ir	npatient 2		DOA Other Nur		Residence 6 Oth	er:
ding Ph After t funeral	on: T		Day, Year)	28b. Time of Injury	28c. Injury at Work?	1.	now injury occurred	
ivisior I or Attend after death Director:	ertification:	2 Accident Prestigation 28e Place		9:31 am ome, farm, street, factor		28f. Location (S	Street and Number or F	Rural Route Number, City
Divisior pital or Attencours after death neral Director: filled in by the	ertif	Suicide Could not be	found at			Delta, PA	tate 211 Forest N	View Dr
D To the Hospital within 24 hours To the Funeral	cal C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of	t of my knowled	ge, death occurred at the	e time, date and place, a	nd due to the caus	e(s) and manner as sta	arted
To th withii To th comp	Medical	29b. Signature and title of certifier	ated.		9c, License number		29d Date signed (N	
		TP 1 11 7	0/		O.C.M.E.		June 11, 2006	
0		30. Name and address of person who completed caus		(3/2) 1 23a)			L	
		Theodore King MD. Assistant Medi	cal Examine		eet, Baltimore, MD	21201		
S Regis	tate trar		gistrar's Signart	are Speaker	<u> </u>			

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Fegistrar's Signature

		For State Registrar		Department of Health and Note that the Control of Contr	•	
				Certificate of Death		eg. No.
Dhyeio	ion	Decedent's Name (First, Middle, La	ist)		Date of Deat Month	th 3. Time of Death
Physic /Medi		Lloyd Jones			June	11 2006 1:25 AM
Exami		4a. Facility Name (If not institution, given	ve street and number)	4b. City, Town, or Location of Death		4c. County of Death
		410 Secluded Po	ost Circle Apt	A Glen Burnie		Anne Arundel
Funeral			Sex 7. Age (In yrs. last b		8. Date of Birth	
Director			X □M 2□F 90	Mantha Dave House Min	8. Date of Birth (Month, Day, Feb 8	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. It heelth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-1 show other traumatic event, Ite Medical Examinar must be multiled at	ctor	10a. State 10b. County Maryland Anne A		wn or Location		10d. Inside City Limits 1 ☐ Yes 2 No
h with th	Funeral Director	10e. Street and Number 7641 Old Teleg	raph Rd.	10f. Zip Code 21144	1	0g. Citizen of What Country? USA
de de de	e	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ours after rel', or ite	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give Y Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XXNo Specify:	Rican, etc.)	Black, White, etc. Specify: Black
within 72 ho ene. than "natur to Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Industry
The state of the s	E	6th	0	Farmer		Hawkins Farming
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma		17. Father's Name (First, Middle, Last	"	18. Mother's Nam		Maiden Sumame)
should be ind Mental I marked o umatic eve	Be	Basil Jones			Spriggs	•
Me Me	ဥ					
and 2 sr lee!th and m 27 le n her traun		19a. Informant's Name/Relationship (Denise L. Bouye		b. Mailing Address (Street and Number or Rui 0 Secluded Post C		
tan tan othe		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date	20c. Location - City or Town, State
Pages nent of int: If it		1 XBurial 2 Cremation 3	Themoval from State C+ D	ery, crematory or other place) lest Cemetery 6-1		Hanover, Md.
nit. Pa bertmen cortant: injury &		4 □Donation 5 □ Other (Special	**			
permit. Pages 1 ar Depertment of Hee Important: If itam eny injury or other QDCG.		21. Signature of Funeral Service Lice	nsee	Wm.Reese & Sons 821 West St. An	Mortua	ry, P.A.
		23a. Part1. Enter the disease, or con-	plications that caused the death. Do	not enter the mode of dyjag, such as cardiac	or respiratory arre	est, Approximate
Physician /Medical		shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	omage frostate		Interval Between Onset and Death
Examiner		Conventially list conditions	b	Fredkinal M	4012914	4
ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		
be executed sicien and burial-transit	E	that initiated events	c	themonic	,	
exe an ar rial-t		resulting in death) Last	Due to (or as a consequence	of):		
se be ey	cai		d			
ficat pph)	D					
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ires that the de signed by the a I be detached f		Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
w requires been sign should be	ed by					es 2 No 3 Probably 4 ∐Unknown
w requ	et				24a. Was ar	n 24b Were autopsy findings available
The lay	Completed	/			autops: perforn	v prior to completion of cause of
iding Physicien: The th. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Other	h (Check only on	3/ 1/11/0/018
Atter th		27. Manner of Death 1	28a. Date of fnjury (Month, Day Year) 28b.	Time of 28c. Injury at Injury Work?		w injury occurred
or Atter efter dea Director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	De Co- Diese of leive. At here 4	M 1 □ Yes 2 □ No arm, street, factory, office	28f. Location (Sti City or Town	reet and Number or Rural Route Number, , State)
Nospital	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicaf Exam	hysician: To the best of my knowledg miner: On the basis of examination a and manner stated.	le, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the ca red at the time, da	uuse(s) and manner as stated. ate and place, and due to the cause(s)
To the within 2. To the I complet	Me	29b. Signature and title of certifier	\wedge	29c. Ligense number	/ 25	9d. Date signed (Month, Day, Year)
1		30. Name and address of person who	complete (cause of death (Item 23a)	Type Print)	1	6/13/2006
		7575 Ri	tokile High wo	ry Glen Burnis	2 MD	21061/Dr. AniXCI
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Coast 1		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2006-19057 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician \$ 9:20 PM etchev Johnson 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Apt 704 S. 2503 Vio 5. Social Security Number Are Violet 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Year **Funeral** 1 2NM 2□ F NO Director 230-58-6439 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show may injury or other traumatic event, its Mardial Examiner must be notified an once. 10a. State 10b. County 1 ☑ Yes 2 ☐ No Kaltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2503 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Un K 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mac rearlie Mattie Johnson DOXIC 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25801 Brenda Beckley, WV Beckwood Lorraine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Beckley, Men. Hack! 4 Donation 5 Other (Specify) 6/12/2006 GREENWOOD 22. Name and Address of Facility

Cough C. Greene Funeral Svc 21. Signature of Funeral Service Licensee 5151 Balto. Nati Pike, Baltimore, MD 21229 evene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (on as a consequence of) Examiner attending physician and for use as the burial-transit 29 The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Mo 24a. Was an has le 2 autopsy 1 Yes 2 No certificate Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 70 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After thi Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 13 2006 death (Item 23a) (Type), Print) s of pers tho completed cause 30. Name and addres 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, per/II, 0856,6/16/06 II

		1	State of Maryland / Dep	artment of Health and Menta <i>rtificate of Death</i>	Hygiene 006 19058
3	Physicia	an	1. Decedent's Name (First, Middle, Last) Lois Jenni	Mor	of Death th Day Year 1942 M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Level Veller 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death ###################################	4c. County of Death of Birth hih, Day, Year) 9. Birthplace (State or Foreign Country)
- 2	Director		220 18 2652 1 M 2 T 79 Yrs. Usual Residence of Decedent	apr	.10 1927 VA.
	aryland ehow	5	10a. State 10b. County 10c. City, Town or L 4D N/A BALTIMOR		10d. Inside City Limits X□ Yes 2 □ No
	n with the N 3a or 28a-f	Direct	10e. Street and Number 1711 latrobe ST.	101. Zip Code 21213	10g. Citizen of What Country?
036	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or teme 23a or 28a-f ehow event, the Modical Exart and most be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes Civit Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 ☒ No Specify:	s or No- ltc.) 14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	filed within 72 ho Hygiene. ther then "natur ither the Medical	Completed	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) ER PARENT	16b. Kind of Business/Industry SELF EMPLOYED
pu	should be filed within the Mental Hygiene. marked other then male event, the Mental count, the Mental	Be	17. Father's Name (First, Middle, Last) NATHANEL JENNINGS	18. Mother's Name (First, ALBERTA ST	Middle, Maiden Sumame)
<u>a</u>	w = = 3	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
	s 1 and 2 if Health a Item 27 le		20a Method of Disposition 20b. Place of Disp		O.MD. 21217 20c. Location - City or Town, State
Baltimore,	Pages nent of I ant: If It		1 XBurial 2 □ Cremation 3 □ Removal from State M7 Condition of □ Other (Specify)	CEMETERY JUNE 17	,2006 BALTO,MD.
Balti	permit. Pages Depertment of Important: If I any Injury or once.	1	MANIACUMO 11-100084 1	ALVIN B. SCRUGGS F	RALTO MD 21213
		1	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or respir	atory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):		
I	Examiner	er	Sequentially list conditions, if any, leading to immediate	cov	
90,	cate be executed physicien and the burial-transit	al Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
68760,		Medical	d		
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be deteched for use as	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.O	w requires that I been signed by should be dete	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		Completed		1	a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2. No Voutpatie	26. Place of Death (Checkers) ont 3 DOA Other: 4 Nursing Home 5	k only one) ☐ Residence 6 ☐ Other (Specify)
	ling After fune		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 27 Accident investigation	of 28c. Injury al 28d. De Work? M 1 Yes 2 No	scribe how injury occurred
Division	Atten r deal ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ration (Street and Number or Rural Route Number, or Town, State)
	Hospitel or 24 hours after Funerel Dir stely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ith occurred at the lime, date and place, and due nvestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	9		30. Name and address of perspn who completed cause of death (Item 23a) (Type	D005 (891	June 12,06
3	•		Sam How 301 St. Ya	ul Mace, Bal-	timero MD 21202
74 6.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	as a file	

		1 - For State Registrar	State of Maryland	d / Depai <i>Cert</i>	rtment of H	lealth a	and Me		giene Reg. No.	2006	1905
		Decedent's Name (First, Middle, Last	")					2. Date of De	ath		3. Time of Death
Physici /Medi		Francis E	. LaMotte					Month	Day - 14-	Year O(a	8:05 am
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location	of Death		4c. C	ounty of Death	
		Franklin Square He	spital Center		Roseda		~		Ba	Himor	e
Funeral		5. Social Security Number 6. Se 212-05-6959	x 7. Age (In yrs. I XM 2□ F 91		If Under 1 Year Months Days	If Under Hours	Min.	3. Date of Bir (Month, Da 01/01	th 1/191	9. Birthp	olace (State or Foreign ntry) nsylvania
Director		Usual Residence of Decedent	91					01/01	1/191	5 Peni	isyivania
within 72 hours after death with the Maryland ane. Then "natural", or items 23a or 28a-f ehow the lical Exaculter must be codified at		10a. State 10b. County		, Town or Loca						1	10d. Inside City Limits
- 1	cto	MD Baltim	ore E	Baltim	ore						1 ☐ Yes 27€ No
Department of results and western rygions. Department of results and western rygions. Any njury or other traumatic event, it a Medical Executar must be notified at ances.	Oire .	10e. Street and Number			10f. Zip Code				10g. Citize	on of What Cour	ntry?
23a	Funeral Director	7904 Rolling			l	1236				USA	
	nue	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spec 1, Puerto R	ify Yes or No ican, etc.)	- 14	 Race - Americ Black, White, 	
Na.	by F	1 ☐ Never Married 2 ☐ Married 312 Widowed 4 ☐ Divorced	1X Yes 2 ☐ No If Yes, Give Year or Dates:	1 (∃Yes 2. XNo	Specify:			s	Specify: wh	nite
9	per	15. Decedent's Edu	ucation	16a. Decede	nt's Usual Occup	ation			16b. Kind	of Business/In	dustry
To H	pie	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give ki life. Di	ind of work done O NOT use retire	du <i>ring</i> mos d)	t of working	7			
110	Completed	12		ste	el wor	ker				teel	
is marked other than raumatic event, it e Mu	Be	17. Father's Name (First, Middle, Last)	T - M - + + -				,	First, Middle,			
atic	ျ	Francis J.						ine F			
Traum		Jane A. McCaul			Address (Street						
E E		20a. Method of Disposition	20b. PI	lace of Disposi	tion (Name of		agent (during last)	-		ation - City or To	32162
t: # 11 y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		atory`or other pla		JUNE				
ulu .		21. Sign to of Funeral Service Licens	IOL		unt Cer		200	6	8800	timore	e. MD ord Rd.
Important: If any injury or once.	Į.	Met so Bell		1	ans Fu		•	pel		ville	
		23a. Part1. Enter the disease, or combo shock, or heart failure. List only o	lications that caused the death	. Do not enter	the mode of dyir	ng, such as	cardiac or	respiratory ai			Approximate Interval Between
sician		Immediate Cause (Final disease or condition	. Aspiration	Pos	00.00						Onset and Death
edical		resulting in death)	a. Due to (or as a consequ		monia						2 days
niner		S ouentially list conditions	b. Hypoxem							C	29445
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	хап	that initiated events resulting in death) Last	c. Hial h	once of):	200						days
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is the burial-transit	edicai		d. 9 101C	red for seri	T. Con GOL					17	lears
for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar						230	d. Date of delive	ary
ad for	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetat 4 Pregnant at time of de 9 Unknown		ctopic pregnancy Other (specify)	/ 				Month	Day Year
	Å.	9 Unknown						_			
d be deteched i	þ	Part II. Other significant conditions co		ılting in the und	lerlying cause giv	en in Part I.					ne cause of death?
should	ted	Lolon Cane	61					101	res 2 🖸	No 3∐Prob	ably 4 Unknown
201	Completed							24a. Was autop	SV	24b. Were auto	psy findings available mpletion of cause of
pag									rmed? 2 No	death?	
ector	Be	25. Was case referred medical examiner?	Hospital:		Oth		of Death	Check only o	ne		
this aldi	.T	1 Yes 2 No	12 Inpatient 2 If	ER/Outpatient 28b. Time of	3□ DOA Oth	4 U Nu		d. Describe h		Other (Specify	y)
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y the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stree				f. Location (S	Street and t	Number or Rura	l Route Number,
i Director: d in by the	erti	4 Homicide	building, etc. (Specify)				City or Tox	vn, State)		,
To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Madical Exami	sician: To the best of my knowner: On the basis of examinati	wledge, death of ion and/or inve	occurred at the tir stigation, in my o	ne, date an	d place, an th occurred	d due to the	cause(s) ar date and pl	nd manner as st lace, and due to	ated.
o the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens					signed (Month,	
i		10/11			2	1-0	74	1			
λ		30. Name and address of person who co	ompleted cause of death (Item	23a) (Tune Di	rint)	1 60	• 7		6/1	4/02	8: 02m
A /		DR. Imm/asic	1digi 2000 1	-rank li	N Salle	TO DE	110	3a 14	more	MH	8: NAm 2/237
Sta	ate	31. Date filed (Month, Qay Year)	32. Registrar's Signat	ufo An	sall's		111			11.00	
Registi	rar	00H # 0 20	The second	- 19	- Bridge						

State of Maryland / Department of Health and Mental Hygiene 19060 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 08 2006 Loughrey Grace **Physician** 10:51 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel County Glen Burnie Millennium Nursing Home and Rehab. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec. 20, 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months 1 ☐ M 2 🛱 F 85 213-28-3992 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f ehow the Medical Examiner next be notified at 1 Yes 2 No Glen Burnie Anne Arundel Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21060 116 Louise Terr. or Items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 N Widowed 4 □ Divorced natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) n/a other than Elementary/Secondary (0-12) Own Home Homemaker 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Grace
Vandermark Be Pages 1 and 2 should be fil ment of Health and Mental H lant: If Item 27 is marked oft jury or other traumatic even Grace Clayton Swint 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl Hayden (son-in-law) 116 Louise Terr. Glen Burnie, MD 21060 20b. Place of Disposition (Name of cometery, crematory or other place)
Glen Haven Mem Pk. 20c. Location - City or Town, State 20a. Method of Disposition 1 🄀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6-13-2006 permit. Page Department of Important: If eny injury or ance. Glen Bunrie, MD ungral Service Licensee McCully-Polyniak Funeral Home, 3204 Mountain Rd. Pasadena, MD 21122 J. Wayne Osterling Part Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) archa Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner seretia Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ iis certificate has been signi director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🥦 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the fine, date and plane, and due to the naura(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical The letely (Check on one) and manner stated. Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of rson who completed use of death (Item 23a) (Type, Print) #231 Honopolis, MI 31. Date filed (Month, Day, Year) JUN I 6 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		For State Certificate C	of Death	176g. 146.							
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle,Last) CRAIG JAMES LARK		2. Date of Death Month June 12, 2	Day Year 006	3. Time of Death 0638 hrs					
Acces		Facility Name (if not institution, give street and number) 9029 Scotts Haven Drive	4b. City, Town, or Location of Parkville		4c. County of Deat	unty					
Funeral Director			If Under 1 Year If Under Months Days Hours	24Hrs 8. Date of Birt Min. April	h(MM/DD/YYYY) 9 Bii 8,1978 Forei	Maryland					
th the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number 9029 Scotts Haven Drive	Parkville 10f. Zip Code 21234		og. Citizen of What Cou USA						
16 n 72 hours after death wi nan "natural", or items ical Examiner must be	ompleted by Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) College (1.4 or 54) Col	Vas Decedent of Hispanic Origi FYes, specify Cuban, Mexican, Yes 2 X No specify ent's Usual Occupation (Give ki most of working life. DO NOT up ETITET	Puerto Rican, etc.)	White, etc. W. Specify 16b. Kind of Business Welding Co.						
Dre, MD 21215-0036 es 1 and 2 should be filed within 72 of Health and Mental Hygiene If item 27 is marked other than her traumatic event, the Medical	Be C	17 Father's Name (First, Middle, Last) James Michael Lark		Name (First, Middle, Note: Richards	Maiden Surname)						
무무를토루		Janice Lark-Mother 9029	Scotts Haven I			and 21234					
imC Pag ment tant:		1 XBurial 2 Cremation 3 Removal from State Parkwood	other place) d Cemetery	6–16–2006	Parkville	,Maryland					
Balt Departing Departing Importing I	Į	23a. Part I Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility B800 Harford Ro or the mode of dying, such as ca			Approximate Interval					
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Between Onset and Death					
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50, te be executed ysician and burial - transit	/Medical E	AMENDED item#23a-b,27,perME,g856,6/30/06 TT IF FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of deli									
Box 68760, e death certificate be ex the attending physician led for use as the burial	Physician/Me										
P.O. es that the igned by	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pai	1 Yes	prior to						
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Division of Vital Records, tal or Attending Physician: The law requir its after death "I Director: After this certificate has been s led in by the funeral director, page 2 should it	ation: To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpate 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation		? 28d. Describe I	Residence 6 🗸 Other	er Scene					
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by	Certification:	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, s (Specify)		or Town, S	State)	ural Route Number, City					
To the Howithin 24 Part to the Full completely	Medical	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	igation, in my opinion, death occ		and place, and due to t	he cause(s)					
E > E 0	Ž	29b/Signature and title of certifier Calculo C	29c License number O.C.M.E.		29d. Date signed (M: June 13, 2006	onth, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
S Regis	tate trar	and the second s	de								
DHMH 17 Rev 1/2	2001	ORIGIN	NAL								

Board

ORIGINAL

Registrar

State

O. ELIMSSON 31. Date filed (Month, Day, Year)

JUN 1 6 2006

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day M Month Year Physician 10-43A M KATHRYN LUCAS REICH JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood-Genesis **Baltimore** 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 94 Yrs Ohio 578-36-8181 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County i Hygiene. other than "naturel", or Items 23a or 28a-f ehow vent, the Madical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a any njury or other traumatic event, the Madical Examiner must any notes. 4650 Alcott Way Apt. 403 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 X Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Army 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Reich Norma Daugherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2,1117 19a. Informant's Name/Relationship (Type, Print) Karen Silverman 4650 Alcott Way Apt. 403 Owings Mills, Maryland (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 6-17-06 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 recrasse 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** FAILURE TO THRIVE /Medical Due to (or as a consequence of): Examiner PULMONARY GAROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed EPS15 Due to (or as a consequence of): Box 68760, NEUMONA Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pg 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete 1 ☐ Yes 2 ☐ MC To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice After this certifice funeral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: fnjury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Suple 40 DO023120 JUNE 16th 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 110, shakunmale Supre 9650 Sanhap Road 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 6 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 14, 2006 Month **Physician** June Stephen Stanley Lantz 10:00 a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Baltimore Co. Parkville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 11,1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** 216-03-6060 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location 28a-f show Ohn - Expired rthan "naturel", or items 23a or 28a-f sho the Mydical Examiner must be notified at 1 ☐ Yes 2√ No Parkville Director Baltimore Co. Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8830 Walther Blvd. Apt. 213 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene. Is marked other than "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 9 yrs. Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Liszczynski Magdelena Woitowycz Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is in eny Injury or other traum once. Mrs. Shirley F. Smith / Daughter Batlimore, MD 21206 4602 Forest View Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entomoment Gardens of Faith Cem. June 16, 2006 Baltimore, MD 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and to use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sate hes been signed by the a page 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2 ₽ No rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deati 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours af To the Funaral D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) lhe. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18646 monio M. () June 14,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bostevard Parkville, MD 21234 walther Anna Monies 8800 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vionta 2006 umer June /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) Examiner tospice MO∫ der 24 Hrs. 8. Date of Birth Month, Day, If Under 1 Year 7. Age (In yr last birthday) Birthplace (State or Foreign
 Country) 5. Social Security **Funeral** Months Days Hours Min 1X M 2 F 5-46 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or othar traumatic event, the Madical Examinat must be notified at 1 XYes 2 □ No Maryland 10e. Street and Number Funeral Director alawr more 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced 2/2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jame Wontgomer 19a. Informant's Name/Relationship (Type, Print) daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stale, Zip Code) ontanmer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Green Mount Crematory 21. Signa e of Funeral Service License 22. Name and Address of Facility Joseph L. Kus Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart fail.
Immediate Cause (Final **Physician** ucar disease or condition resulling in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and shed for use as the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 1 🗌 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MB. Katharine J. Havisn 110 33717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice Eutaw St 5. Harnson Ralto 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 1 6 2906 Registrar

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Ħ	Funeral			6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		. Date of Birth (Month, Day,	Year) 9. Birth	place (State or I	Foreign
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Baltimore,	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other then "naturel; or Items 23a or 28e-1 show any injury or other traumatic avent, the Madical Exandratic traumatic at 2000.		21. Signature of Funeral Service L	icensee	2	Name and Address of Factors & Reese &	Sons	Mortua	erv. P.A.		
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r			Decedent's Name (First, Middle, I	.ast)							2. Date of Dea			3. Time of	Death
	Physicia		Vera	Eloise	Mit	che11					June 6	, 200	Year 6	10:23	3 P M
	/Medic Examin		4a. Fecility Name (If not institution, g	ive street and num			4b. City,	Town, or	Location of	f Death		4c. Co	unty of Death		
		•	Civista Medica	1 Center			Lal	lata	ì			Cha	arles		
	Funeral		5. Social Security Number 6		. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day	v. Year)	9. Birth Cou	place (State o	or Foreign
	Director		199-32-4345	1□M 2⊠F	83	Yrs.	Idionario	Dayo			Nov. 23	1922		NC	
	2 ,	-	Usual Residence of Decedent 10a, State 10b, County		10c Cib	y, Town or Lo	ocation							10d. Inside Ci	ity Limits
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	8a-1	ect.	MD Char1	es	W	aldorf	10f. Zip	Codo				10g Citizer	Citizen of What Country?		
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	deeth with the Maryland rms 23a or 28a-1 ehow r must be notified at	Funeral Director	6902 Impala Cour	12. Was Dece	dent Ever in U	S. 13.			spanic Orie	ain? (Spe	ecify Yes or No-		Race - Ameri	can Indian,	
	ter d	Ē	1 ☐ Never Married 2 ☐ Married	Armed For	ces?					, Puerto	ecify Yes or No- Rican, etc.)		Black, White		
5	hours after tural', or ite al Exemine	ρ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	9		1 ☐ Yes	2 ⊠ No	Specify:			Sp	pecify: B	lack	
	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of works	ina	16b. Kind	of Business/Ir	ndustry	
2	hin 7	pie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us	se retired)	G WOIK	,,,g				
	filed within 72 Hygiene. Ither then "na'	Completed	12			Ca	are G	iver					ing Ho	ne	
=	0 5	Be (17. Father's Name (First, Middle, La	st)				}	18. Mothe	r's Name	e (First, Middle,	Maiden Su	mame)		
<u>X</u>	Ment Ment arke	ဥ	George Stevens								ackson				
<u>a</u>	2 should be and Mental ie marked ie marked raumatic ev		19a. Informant's Name/Relationship			1.	-				al Route Numbe	_		p Code)	
2	and lealth m 27 her tr		Grace Sherrill	(Daught							dorf, M		603 tion - City or T	own State	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 (e marked eny injury or other traumatic ev QDGs.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3	☐Removal from S	iate	Place of Dispo emetery, cre			1				,		
Ē	: Pa tmen tent:		4 □Donation 5 □ Other (Spe		Ed	enborn				-14-			orn, P		
39	Separ Mpor mpor my in		21. Signature of Funeral Service Lei	ensee	200						riel E. Unionto				me
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Н			shock, or heart lailure. List or	ly one cause on ea	ich line.	1-1	_1	1/20	/	-	or respiratory at			Interval Bet Onset and	ween
,	Physician /Medical		disease or condition resulting in death)	_a	WIL	rese	nu l	pu	hy/						
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89	tifical ng phy as th	Medi	15 5514415												
ŏ	death certific attending pl	an/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		⊒Ectopic p	regnancy				230	d. Oate of delivers	,	Year
P.O. Box	a deal he att	Physician/Med	in the past 12 months? 1 □ Yes 2 ☒ No		ant at time of d		Other (sp						Monut	Day	roai
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<u> </u>	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:	-			Oth			h (Check only o				
o	Phys this aldin	J.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🗆 1	<u> </u>	ER/Outpatie		JA	4 🗆 140	ursing Ho	me 5 Resid			ify)	
L C	ding h. After fune	io	1 Natural 5 ☐ Pending		of Injury h, Day Year)	Injury	М	28c. Injur Wor 1 □	k? Yes 2□	No					
Division of Vital Records,	Il or Attending efter death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	of Injury - At h	ome, larm, st	reet, lactor	y, office					lumber or Ru	ral Route Num	ıber,
<u>S</u>	efter Offe d in b	Certification:	4 Homicide	buildir	ng, etc. (Specil	(y)					City or Tov	vn, State)			
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physician: To the	best of my kno	owledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) ar	d manner as	stated.	
	the Ho hin 24 I the Fu npietely	Medical	(Check only 2 Madical E	kaminer: On the ba and mann		tion and/or if	ivestigation	i, in my o	pinion, dea	un occur					5)
	To the Comp	Σ	29b. Signature and title of certified	U			29	c. Licens	e number			29d. Date s	signed (Month	. Day, Year)	
	d		1 /m. Osto	·]	D210:	31			6/	7/01		
	10		30. Name and address of person w												
	1		Michael A. Le	therwood		. 4			ter,	Ste.	302, W	aldor	f, MD	20604	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 6	2006	egistrar's Signa	ature	pask	<i>P</i>							

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			Registrar 1. Decedent's Name (First, Middle	l asti		Cei	lineale or i	Jean	2	2. Date of Deat	g. No. h		3. Time of Death
	Physicia /Medic		Λ.		May	1			_	June	Day	2006	12:39 AM
	Examin		4a. Facility Name (If not institution	, give street and number)	1 (1	ante.	4b. City, Town, o	11'	Death NOT	P	4c. Cou	nty of Death N/A	
			5. Social Security Number		ge (In lyrs. las	et birthday)	If Under 1 Year	If Under 24	Hrs. 8	B. Date of Birth	Vacel	9. Birthi	place (State or Foreign
	Funeral Director		214-03-7737	1 ☐ M 2 🖾 F	88	Yrs.	Months Days	Hours	Min.	097/184.	1917	Mar	yland
7	2 (10)		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits
Aprilo	e ho	0		imore		utus							1 ☐ Yes 2 ☒ No
4	28a-	rect	10e. Street and Number	Zino Z C	1120		10f. Zip Code			1	0g. Citizen	of What Cou	ntry?
4	3a or	Funeral Director	1205 June Rd				21227				Unit	ed Sta	ites
000	E E	ner	11. Marital Status	12. Was Decedent Armed Forces?		. 13. \	Was Decedent of H	lispanic Origin an, Mexican, I	n? (Speci Puerto Ri	ify Yes or No- ican, etc.)		Race - Ameri Black, White,	
ם פֿ	or it	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No	,	1 ☐ Yes 2 🖾 No	Specify:			Spe	ecify: W	hite
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7	giene er tha	Completed	12	Jones (1.10)			Secretary						LION
ב ב	2 Should be littled within 72 hours arise localit with the waaryand, and Mental Hygiene. I so marked other than "natural", or items 23a or 28a-f ehow raumatic event, the Madical Examinations to notified at	Be	17. Father's Name (First, Middle, Charles Edwa:						- ,	First, Middle, M Ludnur		name)	
a y	and Me	2	19a. Informant's Name/Relations	hip (Type, Print)			ng Address (Street						
20	and sealth m 27 in the tre		John G. May /	son	20h Pla		Heatherw						
altimore	permit. Pages I and 2 should be lighted to the variety aries death with the way has been permit. Pages I and 2 should be lighted to the lighted them 23 a or 28a-1 show any injury or other traumatic event, the Modified Examination to the religious process.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ ther (S		COS	motant crat	the Assum	s) St ption	6/1	6/2006	Gova	ns, Ma	ryland
Salt	permit. Departminporta Importa any inju		21. Signature of Euneral Service	Licensee	0	22	2. Name and Addre	ss of Facility		rose Fu			, Inc. land 21227
	20384		23a. Part1. Enter the disease, or	complications that cause	d the death.							, mary	Approximate
F	hysician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each I	line.		nonia						Interval Between Onset and Death
E	/Medical Examiner			Due to (or as	s a conseque	ence of):	ry Ar	tery	, D)iseas	s-e		y-ears
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o C	ling Ph I. After th Tuneral	lon:	27. Manner of Death 1 Natural 5 ☐ Pendi		jury Pay Year)	28b. Time o Injury	Wo	ryat rx?]Yes 2.∐N		8d. Describe h	ow injury or	ccurred	
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2	safter safter al Dire ed in b	Certification:	4 Homicide	building, e	etc. (Specify))				City or Tow	n, State)		
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Park A	Sta Regist	ate rar	31. Date filed Month, Day, Year JUN 1 6	2006 2006	trar's Signat	GOZ.	also				,		

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Charmane McElroy 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day June 11, 2006 1510 hrs Charmaine McElroy Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Harbor Hospital n/a If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Foreign Min Director 215-40-6295 Country) 1 M 2 X F 64 17. 1942 Jan. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits an, 10a State 1 Yes 2 XNo fshow Anne Arundel Brooklyn Park Maryland hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 28a-1 10e. Street and Number notified at 603 Lorca Avenue 21225 USA 23a Funera 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 X Married Yes 2X No f Yes, Give Year 1 Yes 2 X No specify: Specify. White Divorced 3 Widowed 2 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72. nent of Health and Mental Hygiene. narked other than event, the Medical MD 21215-0036 0 Homemaker Own Home 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Emory O. Ritenour Elizabeth Bryant 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tivis McElroy / Husband 603 Lorca Avenue, Brooklyn Park, Maryland 21225 it: If item ? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a Method of Disposition Baltimore, 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 6/15/2006 | Baltimore, Maryland Important: injury or otl tment Donation 5 Other Specify 22. Name and Address of Facility Turon Unera Home, Inc. Signature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a, Pall I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Complications of chronic alcohol abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical ttending physician are use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P. 0. ð 1 Yes 2 V No 3 Probably 4 Unknown Completed of Vital Records, peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has page 2 s death? performed? this certificate Yes 2 1 🗸 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi stely filled in by the funeral director, 25. Was case referred to medica Be examiner? Hospital: 1 Inpatient 2 🖊 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 2 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 V Natural Division 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 12, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month; Day

OCMF 2006

State

Registrar DHMH 17 Rev 1/2001

2006 6

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE Day 11. **Physician** 2006 1:15 PM GEORGE MAY JOHN /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**M** M 2□ F 211-09-4910 Usual Residence of Decedent MARCH 9, 1917 MARYLAND Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or flema 23a or 28a-f show eny Injury or other traumatic event, ILa Madical Exercises must be accessed. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 3602 FAIT AVE U. S. A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 RECORDER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY KOHLES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE MAY 19a. Informant's Name/Relationship (Type, Print) 3601 FAIT AVE, BALTIMORE, MD, 21224 LORRAINE MAY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ⚠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER CEM, JUNE 17 Jack BALTIMORE MD.

22. Name and Address of Facility LILLY & ZEILER, INC. FUNERAL KENE 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 700 S. CONKLING ST., BALTIMORE, MD Z1124 Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner SEVERE AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 ER/Outpatient 3 DQA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide hours after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12/06 D37254 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON LIM, MD 7601 OSLER DRIVE TOWSON, MARLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 16 2006 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Amend Items	s State of Ma s 236,25 p	eryland, G856	artment 06/14 rtificate	1966 of L	ealth a Death	and M	ental Hy	giene Reg. No.	2006	1907	
	i	- 2	Decedent's Name (First, Middle, La							2. Date of Dea Month			3. Time of Death	
ŧ	Physici /Medic		Mary Louise Mohr							April		, 2006	0435 ^M	
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	Funeral		5. Social Security Number 212-10-9209	Sex 7. Ag 1□M 2√√√F 8	e (In yrs. last birthday 8 Yrs.) If Under 1 Months	Days	Hours		8. Date of Birth Month Day 09/20/1	y Year)	9. Birt Co Mal	hplace (State or Foreign untry) "Yland	
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	yland		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits	
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	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Decede If Yes, specif	ent of His ify Cubai	spanic Orig n, Mexican	gin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		 Race - Ame Black, White 		
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_	(5)		30. Name and address of person who David Smi	th 29	death (Item 23a) (Type 1+66 P	ntai	10	m., 5	Suit	e5+	6	Easto	n, mD	
	St. Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 4 2005	32. Registr	rar's Signature	les .								

			For State Registrar	State of	Marylar		artment of H		d Mental H	ygien Reg. N	C. U.	36	19072
	Physici		Decedent's Name (First, Middle, Last) Raymond J. Newman						2. Date of D Month		ay \	rear .	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s		per)		4b. City, Town, o	or Location of D	June June	4c. County of De			11:00a [™]
			Greater Baltimore	e Medica	al Cen	ter	Towson			E	Baltim	ore	
	Funeral Director		5. Social Security Number 6. Sex 219-01-0969	M 2□F	. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of B Min. (Month, D March	ay, Year	1921		nce (State or Foreign y) rland
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
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Mar	12 shou h and M 7 le marl raumati		19a. Informant's Name/Relationship (Type Gloria Roeger, Da				ng Address (Street High Past					ate, <i>Zip C</i> 21014	/
, e	1 and Health tem 27 other tr		20a. Method of Disposition	ugniei	20b. F	lace of Dispo	sition (Name of		Date	-	ocation - Ci		
₹Ē			1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from St	ate C	emetery, crei	natory or other place Forest V	'	ne 16. 20				
Baltij	permit. Pages 1 and Department of Health important: if item 27 eny injury or other troops.		21. Signature of Funeral Service License	3		22	2. Name and Addre	ss of Facility	Miller-D:	ippe:	l Fune	eral	Home, Inc.
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	Physician		Immediate Cause (Final disease or condition	12F	57112	MUCH	ZU A	ref	ST				nterval Between Onset and Death
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isio	Attendideath.	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No					
Div	rs efter rs efter ral Directed in by	Certification:	4 Homicide determined	building	etc. (Specify	ome, farm, str	eet, factory, office		28f. Location City or To	(Street ar wn, State	nd Number e)	or Rural F	Route Number,
	To the Hospital or Attentwithin 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	ician: To the be er: On the basi and manner	is of examina	wledge, death tion and/or inv	occurred at the tim restigation, in my of	ne, date and pla pinion, death of	ace, and due to the courred at the time	cause(s date and	and mann d place, and	er as state d due to th	ed. ne cause(s)
	To the comp	Σ	29b. Signature and title of certifier	2 12-	,	0	29c. License	e number	1	29d. Da	te signed (/	Month, Da	y, Year)
	2		JIMNEST M			May		1) 27	-43+	06	15	100	
	4		30. Name and address of person who con	mpleted cause of	of death (Item		Print) M, 67	01 N.	combs	87.	Bal	hmi	re Md.
-2	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 6 20		istrar's Signa		rest						

Registrar

			State of Mary	rland / Department of Health and Mental Hygiene	10073
			State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death Reg. No.	1010
	Physici		Gertcide M	POOLOCKI 2. Date of Death Month Day Year TONE 14 2000	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	20.001.
			5. Social Security Number 6. Sex 7. Age (In		RD.
	Funeral Director		215-01-95-3	Yrs. Months Days Hours Min. (Month, Day, Year) Cour	place (State or Foreign ntry) 7 MOR = 1116)
	and		Usual Residence of Decedent 10a. State 10b. County 10c		
	Maryia -f sho	tor	MD HARFORD	FUEFFT HILL	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the or 28e)irec	10e. Street and Number	10f, Zip Code 10g, Citizen of What Cour	ntry?
	s 23a	erai [703 Dewey Ct.	21050 USA	
ထ	after de or Item cinera	Fun	11. Marital Status 1 Never Married 2 Married 2. Was Decedent Ever Armed Forces? 1 Yes, Give		etc.
003	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28e-f show int, Ite Madical Exercit et rivist Le radiified at	Completed by Funeral Director	3 Devolutioned 4 Divolced Year of Dates:	1 Yes 24 No Specify: Specify: W	rite
21215-0036	in 72 n "net Madic	piete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Inc	dustry
	filed withi Hygiene. other ther ent, ILE M	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Lab Worker Armed St	eel.
and	ould be fil Mental H arked oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	2 should be and Mental Is marked ceumetic eve	70	15a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	Code)
	1 and 2 Health a em 27 Is ther tree		Diane Di Benedetto	763 Dewey CF. Forest Hill, MD 2	1650
Jore	Pages 1 nent of Hi ont: If iter iry or oth		1 Burial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Name of cametery, crematory or other place) Date 20 Location - City or To	wn, State
Baltimore,	1 5 E F		' 4 □ Donation ' 5 □ Other (Specify) 21. Signature of Funeral Se vice Licensee	SPECIMENT OF THE CONTROL OF THE MORE 22. Name and Address of Ficility	MU
Ö	permi Depa Impo eny ir once		Kinberly (1. Zartother	EVANS FUNERAL CHAPE-BELAIR 3 No	FWADRT 12
			snock, or heart failure. List only one cause on e. ch lin s.	death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Eschemic Heart Disease	13 years
	Examiner		Due to (or as a cor	issequence or):	
	sit s	iner	if any, leading to immediate Due to (or as a cor cause. Enter Underlying	nsequence of):	
	axecute n and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cor	nsequence of):	
760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical	d		
39 x	death certifica attending ph d for use as th	/Med	IF FEMALE: 23c. If yes, outcome of pri		
Вох	res that the death cer igned by the attendin be detached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time	Fetal death 3 Ectopic pregnancy	ory Day Year
P. O.	at the d	hysi	9 ☐ Unknown		
	signed d be de	þ	Part II. Other significant conditions contributing to death but not		ably 4 ①Unknown
Records,	w requir s been si should	iete			osy findings available
		Completed			npletion of cause of
VIta	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
ō	Phys ar this aral dir	n: To	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 27. Manner of Death 1. Natural 5 ☐ Pending (Month, Day Yea	2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, ar) 28b. Time of Injury at Work?)
ion	anding ath. or: Afte	atio	2 Accident investigation	ar) Injury Work? M 1 □ Yes 2 □ No	
Division of	or Atterder de Directorin by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury 1 building, etc. (Sp.	At home, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State)	Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, to		29a. Certifier Lectifying Physician: To the best of my	r knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta	ated.
	the Ho iin 24 I the Fu apletely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to	the cause(s)
	To To con	2	29b. Signature and title of centrier	29c. License number 29d. Date signed (Month, D	- /
	Δ		30. Name and address of person who completed cause of death	(Item 23a) (Type Print)	
	D		Vincent A Girminero Do 418	Worth Array \$310 Bel Acilles 21014	
	Sta Registra	6	31. Date filed (Month, Day, Year) JUN 1 6 2006 32. Registrar's S	ignature	

DHMH 17 Rev 1/2001

Popiachi, Gertrude

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 **Physician** Month June 13, 3:05 Helene Piccione Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/05/1921 9. Birthplace (State or Foreign Country) New York **Funeral** Months Days Hours 1 - M 20XF Director 84 107-16-7800 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location rthan "natural", or iteme 23s or 28a-f ehow the Madical Examinational be notified at 10d. Inside City Limits 1 Tes X No Directo Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7420 Lakeview Drive 20817 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na eny Injury or other traumatic event, In a Madig Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Hlipala Anna Kuritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Adams Lane Airmont, NY 10901 Joan Grillone/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Anthonys Cemetery 06/19/2006 Nanuet, NY 21. Signature of Fundamental Services 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) minute /Medical Due to (or as a consequence of): Examiner WEEK if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physicien Physician/Medical CVA IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ŏ Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy After this certificate 1 ☐ Yes Z No Hospitel or Attending Physician: ieral Director: Atter this certific filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the to the eausu(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Madlea D0063129 JUNE 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADKARNI 940 Halical Penter Dr. Rokulle, MD 20550 DOMLLIMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 6 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle,	er5, 6870, 8/30/07 T	T Octain	cate of		2. Date of Death	g. No.		3. Time of Death
Physici			,				Month	Day	Yeer	2:25 A M
/Medic		Lucille 4a. Fecility Name (If not institution.	Pinkett give street and number)		City, Town, or	r Location of Death	06	4c. County	06 of Death	
Examin		Potomac Valley N	•		Rockvi			Mont	gomer	v
Funeral			6. Sex 7. Age (In yrs.	last birthday) If l	Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign y)
Director		238 24-7917	1□M 2፟ 82	Yrs.	nths Days	Hours Min.	06 21	23	North	Carolina
\$ 1980		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Location	n	<u> </u>			100	d. Inside City Limits
28a-f show notified at	ō	,		Lanham					100	tx☐Yes 2☐No
28a-1	ect				Of. Zip Code		10	g. Citizen of W	/hat Countr	v?
10 10	<u>a</u>	10e. Street and Number Rexford Place 9885 Greenbelt	Rd.	"	20706			USA	THE COUNT	, .
in results are when ryseries of terms 23a or 28a-f show them 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was I		ispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race	- Americar	
ar Ita	ᆵ	1 Never Married 2 Marrie	Armed Forces? 1 ☐ Yes 2 ☒ No	ĺ	s, specify Cuba ∕es 2⊠ No		o Hican, etc.)		k, White, et	
E. E.	l by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		105 2 E3 140	Specify:		Specify:	Blac	ĸ
natu	Completed	15. Decedent's (Specify only highest		16a. Decedent's (Give kind	of work done	durina most of wor	king	6b. Kind of Bu	siness/Indu	ıstry
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nt, ED		17. Father's Name (First, Middle, L	<u> </u>	OILLU E	Service		ne (First, Middle, M			Labor
o per	o Be	Rev. R. G. Can					nnie PArh		-,	
mark	ř	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailing Ad	Idress (Street		ral Route Number,		State. Zip C	Code)
Health and tem 27 is rother traur		MArtin E. Pink	ett/Nephew				enn Dale,	•		,
item		20a. Method of Disposition	20b. I	Place of Disposition cemetery, cremator	(Name of			Oc. Location -		n, State
ry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Hemoval from State	Rock Cree			5-06 พ	ashingt	ton. I	D . C .
Department of Heal Important: If item 2 any Injury or other once.	- 1	21. Signature of Funeral Service L					rshall's			
any Ir		D. P ma	Ushall	4217	9th.	St. N.W.	Washingt	on, D.0	200	011
		23a. Part1 (Inter the disease, or cashock, or heart failure. List of	complications that caused the dea	th. Do not enter the	e mode of dyin	ng, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
sician	. 1	Immediate Cause (Final disease or condition	Demen	ntia					(Onset and Death
ledical aminer		resulting in death)	Due to (or as a consec							
illiei		Sequentially list conditions,	b							
sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):						
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phy:	edic		d							
attending physician and for use as the burial-transit	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta					23d. Date	of delivery	/
e atte	icia	in the past 12 months? 1 \(\sum \) Yes \(2 \) \(\frac{\frac{1}{2}}{2}\) No	4☐Pregnant at time of d		pic pregnancy er (specify)			Mon	ith D	ay Year
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is certificate has director, page 2	То Ве	examiner? 1 ☐ Yes 2 🔀 No		ER/Outpatient 3			28d. Describe how	v injury occurre	∍d	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6 2006 Year **Physician** Sheppard 2` 3:30p George Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA 1423 Townway Ct. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4–28–4 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. **X**□M 2□F 218-34-7883 Yrs. Va. 66 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ehow r then "natural", or items 23a or 28e-f ehov the Medical Examinar must be notified at X□Yes 2□No Baltimore NA Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 1423 Townway Ct. Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. uit. Pages 1 and 2 should be filed within 72 hours after satment of Health and Mental Hygiene. crtant: If Item 27 is marked other then "natural", or ite injury or other traumatic event, the Medical Examination. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ Black 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Chef 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sheppard Bul1 Virginia David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1423 Townway Ct., Baltimore, Md. Lucille Gross Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Md. 6-6-06 Greenmount Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit.
Departr
Importu
any info 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Examiner physicien and the burial-transit Physician/Medicai the δ cate has been sig , page 2 should b Completed After this certificate b Be 2 Certification:

Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funerel Director: the

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):									
resulting in death) Last	Due to (or as a conse	quence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	el déath 3 □Ectopio			23d. Date of delivery Month Day Year					
Part II. Other significant conditions	contributing to death but not re	sulting in the undertying	g cause given in Part I.	\ /	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
				24a. Was an autopsy performed 1 Yes 250						
25. Was case referred to medical examiner?				ath (Check only one)						
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 □Other (Specify)					
27. Manner of Death Natural 5 Pending Accident investigat		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ljury occurred					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, street, fact ify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
29a. Certifier (Check only one) Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	iswladge, death commination and/or investigati	ad at the time, date and plan on, in my opinion, death occ	e and due to the cause urred at the time, date a	(s) and manner as stated and place, and due to the cause(s)					
29b. Signature and title of certifier	in Beet ?	The D	DZ 4PP		Date signed (Month, Day, Year) LNC 13,200 6					
30. Name and address of person when 1838	CA 010 0 1-1	om 23a) (Type, Print)	d baltime	re MO						
and a second of the second	00 /	and the same of th								

Medical

State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE **Physician** Thomas Glen Shepherd, Sr. 14, 2006 3:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay. NOV • 12, 5. Social Security Number Sex XXM 2□F 7. Age (In yrs. last birthday) 73 Yrs. 9. Birthplace (State or Foreign **Funeral** Year) 1932 Warrensville,N.C 213-30-7106 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits me 23a or 28a-f ehor Baltimore County Cockeysville 1 Yes 2 No Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10913 Gateview Road 21030 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. The Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 ö Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Proctor and Gamble Landscaper N/A 7 le marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glen Shepherd Sibbie Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mrs. Philomena M. Shepherd 10913 Gateview Road, Cockeysville, Maryland, 21030 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ot once. Greenmount Cemetery June 16,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral Cremation Ctr. P.A. 2325 York Road Timonium Maryland, 21093 21. Signature of Funeral Service Licenses otott مهل 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **EMPHYSEMA** 6 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) O. Box 68760. physician s the buria Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ACUTE RENAL FAILURE 1 X Yes 2 🗌 No 3 Probably 4 □Unknown SHOCK 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No certificete has to irector, page 2 sl 24a. Was an 2 No 1 ☐ Yes 2 director 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cilla M.D. June 14,2006 D 36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART R. WILLES, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State JUN 1 6 2006 Registra

		For State Registrar	State of Maryland / Depa	artment of Hea rtificate of De	ath	Reg	ene 2006	19078
Physici /Medic		Decedent's Name (First, Middle, Last)	Millard R. Smith			Date of Death Month	14 2006	3. Time of Death
Examir		4a. Facility Name (If not institution, give s Baltimore—Washingt	treet and number) con Medical Center	4b. City, Town, or Loc Glen Bu:			4c. County of Death Anne Arun	del
Funeral Director			7. Age (In yrs. last birthday)		Jnder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day,) (ay 11,		lace (State or Foreign htry) yland
e Maryland 8-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town or Lo	Balti	imore		1	0d. Inside City Limits 1 No 2 □ No
h with ih	Funeral Director	10e. Street and Number 421	Maude Avenue	10f. Zip Code	21225	100	g. Citizen of What Cour	ntry? ISA
21215-0036 within 72 hours after death with the Maryland liene. Ithen "natural", or items 23s or 28s-1 show the Madrical Examinar must be notified at the Madrical Examinar must be notified at	by Funer	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	1 TXYes 2 □ No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🔼 No Sp	nic Origin? (Speciflexican, Puerto Ric pecify:	y Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
within then the Mark	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation (Give (Give (ife. i	dent's Usual Occupation kind of work done durin DO NOT use retired) Stevadore	g most of working	16	Bb. Kind of Business/Ind Dockworke Union Loc	ers
land 2	Be	17. Father's Name (First, Middle, Last)	Ralph Smith	18.	Mother's Name (A	First, Middle, Ma		
Maryland 2 should the and Me 27 ie mark recommend	2	19a, Informant's Name/Relationship (Ty) Darlene Olecski	(D L)	ng Address <i>(Street and I</i> 19 Wasena A		Route Number, (City or Town, State, Zip	
MOFE, Pages 1 are of Hear of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State 20b. Place of Dispo cemetery, cref Glen Hav	esition (Name of matory or other place) ven Mem. Pk	Dat	9 20 06 G	oc. Location - City or To Len Burnie,	Mary1and
Balti permit. Depertm imports eny inju		Ken	cations that caused the death. Do not ent	Accully-Pol 237 E. Pata				225-1856
Box 68760, asth certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Otherwise Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Cardiona	,udar	disco	ue_	Onset and Death
I Records, P.O. Box 68 The law requires that the death certifics ate has been signed by the attending plage 2 should be deteched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ds, P.	ρ	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	nderlying cause given in	Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ital Records, ien: The law requires t riflicate has been signe stor, page 2 should be o	Completed					24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
> : 8 5	o Be	25. Was case reterred to medical examiner?	lospital: ix Inpatient 2 - ER/Outpatier	Other	Place of Death (ce 6 □Other (Specif	y)
ion of inding Phy ath. or: After this	ation: T	27. Manner of Death Natural 5 Pending Naccident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	f 28c. Injury at Work?			injury occurred	
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Division C To the Hoepital or Attending P within 24 hours effer death. To the Funeral Director: Affer t completely filled in by the funera	Medical	(Check only one) 7 Medical Examin	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinio	n, death occurred	at the time, dat	e and place, and due to	the cause(s)
To t To t	Σ	29b. Signature and title of certifier	14 A A	29c. License nu		-	d. Date signed (Month,	
102		30. Name an 1a nress of person who co	ompleted cause of death (Item 23a) (Type,	Print) DAS	. 0.	٠.	une 14 W. 210	11
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	- 4 ×	Decedent's Name (First, Middle, Last)		Rag. N	3. Time of Death
Phys			SMITH	JUNE /	13 200/ 5/30 AM
	dical miner		4b. City, Town, or Location of Deat		c. County of Death
		8029 SOLLEY KOAD	GLEN BUI	RNIE	ANNEARUNDEL CO.
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.		9. Birthplace (State or Foreign Country)
Directo	or	Usual Residence of Decedent) rrs.	UCT. 26,1	960 MARYLAND
/land	R		r, Town or Location		10d. Inside City Limits
Mar.	ţ	MARYLAND ANNE ARUNDEL	GIEN BO	URNIE	1 ☐ Yes 2 ₺No
th the	lrec	10e. Street and Number	10f. Zip Code		Citizen of What Country?
ath wi	la I	8029 SOLLEY ROAK	2100	60	USA
er deg	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
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should be nd Mental marked o	ို	ROBERT SMI		IAN	STEVENSON
2 6 8 8		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ri	- / -	
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	oi l	21. Signature of Funeral Service Licensee	ZION U. M. C. CEMETERY 06 -	11-06 PA	SADENA MARYLAND
permit. Departimport	SDCs	Le Dietresh 1/William	JOSEPH HI	ORQUIN VI	BNITA MA 21217
K.		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardial	c or respiratory arrest.	Approximate Interval Between
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/Medica		resulting in death) a. Due to (or as a consequence)	ence of):	13	· · · · · · · · · · · · · · · · · · ·
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier Check only one) 29a. Certifier Check only and manner stated and manner stated.	riedge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	i, and due to the cause(s irred at the time, date an	d place, and due to the cause(s)
To the Mithin To the	₹	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
		Kongth Wu	D39 4	VI TU	ne 14th 2006
ir	2	30. Name and address of person who completed cause of death (Item	23a) (Type, Print) 300/ 5, 44	~ ~ ~ ~ ~ ~	2 shoot
10		CHAMA NIWARA	DDA BILLITE	ax N	D 21225
Regi	State strar	31. Date filed (Month, Pay, Year) 6 2006 32. Red Strar's Signatu	Il Coarles		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 13 17:53 M Smith June Louis , /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 2801 Creston Road ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
November 5,1956 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F 49 Yrs Maryland Director 220-68-2430 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show says injury or other traumatic event, the Modral Exacting frout be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Dundalk Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2801 Creston Road 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 years Steel Worker Stee] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis E. Smith Sr. Phillys Anne Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 405 Crisfield Road, Baltimore, Maryland 21220 Louis E. Smith III June 17, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 2006 Baltimore City, MD. . Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** mucande disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ condictos cular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{\text{\text{Nursing Home}}}\) 1 Nursing Home 5 \(\text{\text{Residence}}\) Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify) 1∰Yes 2□No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . Crotsen O Gnovan MD D0007632 June 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD J. CROSSAN O'DONOVAN 2112 DUNDALK AVE. IND. 31. Date filed (Month, Day, Year) 32 agistrar's Signature JUN 1 6 2006 Registrar

Bernardo Ramon Sanchez

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 19081

		Registrar Certificate of Death Reg. No.												
Physici Medical Exam		202110200	R. Sanc	hez						Date of De Month Vay 8, 20	Day	Year		3. Time of Death 1749 hrs
		4a. Facility Name (if not institution Chesapeake House T	,				City, Town, or L Iorth East	ocation of [Death			c. County o Cecil	f Death	
Funeral Director		5 Social Security Number Unk		(In yrs. las	t birthday) Yr	N	Under 1 Year Months Days	If Under 2 Hours	24Hrs. 8 Min.			1951	Foreia	hplace (State or number) Cuba
l ow any e.		Usual Residence of Decedent 10a. State 10b. County		_	own or Loca	ition		1						10d. Inside City Limits 1 Yes 2 X No
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Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from Sta	te cre	ematory or o	ther p				ate	1	Location - (-	
Baltimore, permit Pages 1 at Department of He, Important: If ite		Almwood Cemetery 5-15-06 Met 21 Signature of Funeral Source Livensee 22. Name and Address of Facility Farrah Funer								eral Home				
		Lennes 30	ettmin				Lawrenc	ce St.	, La	awrenc	ce,	MA O	184	1
Physician /Medical		failure. List only one cause	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		al Hemor	rnag	<u>e</u>					.		Death
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ecol he law ute has	lduc								_	autor perfo 1 V Yes	rmed?	de	ath?	empletion of cause of
tal Rection: The certificate ector, page	Be C	25. Was case referred to medica					26.Place of	f Death (Ch	neck only		2 N	0 1	Yes	2 No
Vit;	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier		R/Outpatient	-		ther N	ursing H	ome 5	Reside	nce 6 🗸	Other.	Scene
Division of Vital Records, rate or Attending Physician: The law requir as after death. In Director: After this certificate has been seled in by the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Pend	28a. Date of Injur (Month, Day,Ye	y 2 ar)	8b. Time of	Injury		at Work?		d. Describe	how inju	ary occurred		
ivisior or Attenc after death Director: I in by the	Certification:		stigation 28e. Place of Inju	ury - At hom	e, farm, stre	et, fac	ctory, office buil	lding, etc.	28f			nd Number	or Rura	al Route Number, City
Dj ospital hours a meral l		4 Homicide	rmined (Specify)							or Town, S				
Division of Vital Records, P.O. Box 68760, within 24 broats after the death certificate be executed within 24 broats after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only Certifying Pi	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, ination and	death occu or investiga	rred a tion, i	nt the time, date n my opinion, d	and place, death occurr	and due	to the caus time, date	e(s) an and pla	d manner as ice, and due	s starte to the	d cause(s)
	Σ	29b Signature and title of certifie)			29c License r O.C.M.				1		(Mont	h, Day,Year)
		30. Name and address of person	who completed cause of de	ath (Item 23	Ga)		U.U.IVI.				iviay	9, 2006		
0		Patricia Aronica-Pollal	k MD. Assistant Me	edical Ex	aminer	111	1 Penn Stre	et, Baltir	more, I	MD 2120	1			
Si Regis	tate trar	31. Date filed (Month, Pay Year) 6 2006 32. Registrar's Signature												
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year GENEVA 0. SMITH 14 2006 /Medical June 7:00 a^M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE OF DULANEY TOWSON BALTIMORE CO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 2 3 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2XXF Months Year) Director MARYLAND 224-16-2496 89 1916 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 Yes 2 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1027 CATHEDRAL ST. APT 9K 21201 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or item any injury or other traumatic event. Affiled Folces?

1 ☐ Yes 2 ZNo

If Yes, Give

Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð 3 ☑ Widowed 4 ☐ Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown DOMESTIC WORKER PRIVATE DUTY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) RICHARD T. GREENE LUCY E ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Nelson/Friend 405 Gwynn Ave., Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 06-20-06 OWINGS MILLS, MD. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Melay WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CORUNARY ARTERY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit Hospital or Attending Physicien: The law requires that the death certificate be executed and physicien a s the burial-Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as esn IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy ò Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by HYPERTENSIUN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Onknown RENAL FAILURE page 2 s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 versing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D D0059107 06-15-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS CENTER DRIVE REISTERSTOWN UMA MD 21136 31. Date filed (Month, Day, Year) JUN 1 6 2006 32. Registrar's Signature State Goods " Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year 9:10A **Physician** SNUL 2006 trom Dera /Medical 4e. Fecility Neme III not institution, give street and number) City. own, or Location of Death County of Deeth Examiner orest Haven Nursing Home

7. Again yrs. last birthday) timore 8. Date of Birth (Month, Day, Year) Jun 16, 1910 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2√F 212-09-3175 89 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 448 1/2 Kent Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed by Specify 3 Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Peges 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: if item 27 ie marked other th
any injury or other traumails Ò Catalog Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Smart Ellen Quinn ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Barrick / Daughter 448 1/2 Kent Avenue, Catonsville, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removal from State New Cathedral Ceme. 6/16/2006 Baltimore, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License Hubbard Funeral Home, Inc. 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSCLEROTIC EREBROVASC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 No 1 🗆 Yes 20 No Physician: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 20 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. After Hospitel or Attending Injury 5 Pending investigation Natural death. 1 TYes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours of To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) 7220 SNEEM \mathcal{D} 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Benjamin Joseph Smith, Sr. June 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 215–82–1230 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 🗆 F 46 Yrs. Director 08/09/1959 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inportant it flem 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Whiteford 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4462 Flintville Road 21160 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ₹ No Specify: Š Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Robert Kenneth Mae Combs 19a. Informant's Name/Relationship (Type, Print)
Melissa S. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4462 Flintville Road, Whiteford, Maryland 21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens 06/19/2006 | Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Foomageal **Physician** 10 months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Within 24 hours after death.

To the Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 12 Certifying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifiler (Check one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min (M.D.) 602 South Atwood Road #200, Bel Air, MD 21014 31. Date filed (Month, Day, Year)
JUN 1 6 2006 32 Registrar's Signature State

Registrar

The great of the

			1 - State of Marylal Registrar		artment of He <i>rtificate of L</i>			ene/ g. No.	J 6	19085
	Physici /Medio		Decedent's Name (First, Middle, Last) PURCELL SCOTT				2. Date of Death Month JUNE 13,	Day	Year	3. Time of Death 9:10 A
	Examin		4a. Facility Name (If not institution, give street and number) VILLA ROSA NURSING HOME		4b. City, Town, or MITCHELI	LVILLE		4c. County of	CE GE	ORGE'S
	Funeral Director		5. Social Security Number 125-16-9307 Usual Residence of Decedent	. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/10/19	926	9. Birthpla Count Virgi	ace (State or Foreign y) nia
	72 hours after death with the Maryland naturel', or items 23a or 28a-1 show ulcal Exacultar front be routified at	Director	10a. State 10b. County 10c. Co	ity,TownorLo per Mar	1boro					d. Inside City Limits
	h with th		10e. Street and Number 13607 Missoula Court		10f. Zip Code 20774			g. Citizen of W JSA	hat Count	ry?
36	rs after deat I', or Items 2	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in the Amed Forces? 1 Yes 2 No If Yes, Sive Year or Dates: 45—		Was Decedent of His f Yes, specify Cubar			14. Race	- America , White, e	tc.
Maryland 21215-0036	C 2	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of works	ng 1	6b. Kind of Bus	siness/Indu	ustry
1d 21	Hyg the	Be Cor	12 17. Father's Name (First, Middle, Last)	Engin		18. Mother's Name		ransit aiden Sumame		rtment
ylan	should be and Mental marked o	ToB	William Scott			Nancy Bov				
	ss 1 and 2 should to the stand Ment of Health and Ment of Item 27 is marked rother traumatics		19a. Informant's Name/Relationship (Type, Print) Audrey Scott/ Wife		ng Address (Street al 7 Missoul					
Baltimore,	permit. Pages t a Depurtment of Hex Important: If Item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place ematory	,		0c. Location - 0	City or Tow	m, State
Balt	Departition in Import		21. Signature of Fureral Service Lizengee		. Name and Address					1 Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dub to for as a conse	Mouc	4	, such as cardiac o		st,		Approximate interval Between Onset and Death
68760, 🌣	ficate be executed g physicien end as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the co							
P.O. Box 6	death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	/ Day Year
	w requires that the been signed by th should be detache	b	Part II. Other significant conditions contributing to death but not re Upper CASTP in the Step	-	nderlying cause giver	n in Part I.			oute to the	cause of death?
of Vital Records,	The law ste has b page 2 sl	Completed					24a. Was an autopsy perform	pr de	or to comp ath?	sy findings available oletion of cause of
ſ Vit	% & E	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes	ER/Outpatien	Othor	26. Place of Death	<i>(Check only on</i> e me 5 ☐ Resid <i>e</i> n		(Specify)	
Division of	ding h. After fune	ertification: T	27. Manner of Death Matural 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe hov			
Divis	To the Hospitel or Attention 24 hours after deatl To the Funeral Director: or mpletely filled in by the	O	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Special Coulding)	fy) 			28f. Location (Stre City or Town,	State)		
	Hosp 24 hou Fune letely fi	edical	29a. Certifier (Check only one) Check one) Che	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and place, a nion, death occurre	and due to the cau ed at the time, dat	ise(s) and man e and place, ar	ner as stat nd due to t	ed. he cause(s)
	To the I	M	29b. Signature and title of certifie	40	29c. License	_	290	d. Date signed	(Month, Da	ay, Year)
•	1/1		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, I	Print)	261	6	-15-	-10.	/
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign JUN 1 6 2006	ature	and a	CI'S ES	CAN	in p	m :	+0+00

Please Type or Print in Black Indelible Ink

	1- For State Registrar	Centitio	cate of Death	Re	g. No. 2001	1911
cal Examinar	Decedent's Name (First, Middle,Last)			2. Date of Death Month June 14, 2	1 3	Time of Death 0635 hrs
our Examinor	4a. Facility Name (if not institution, give st	reet and number)	4b. City, Town, or Lo		4c. County of Death	
	Union Memorial Hospital	T- A- (1 1	Baltimore	Killaday 24l by Doba of Bird	h (MM/DD/YYYY) 9. Birthi	I/A_
Funeral Director	5. Social Security Number 6. Sex 217-38-3219 Usual Residence of Decedent	7. Age (In yrs. last bi	rthday) If Under 1 Year Months Days Yrs.	Hours Min.	Foreign 4,1941	,
Maryland 28a-f show any <u>d at once,</u> rector	10a. State ND . 10b. County N/A	10c. City, Tow BALTIM			1	Od. Inside City Limits X 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	10e. Street and Number 3616 ELMLEY AVEN		10f. Zip Code 21213		og Citizen of What Countr	
	1 Never Married 2 Married 3 Widowed 4 Divorced If	2. Was Decedent Ever in U.S. Armed Forces? Ves 2 No Yes, Give Year		nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.) specify:	14. Race - America White, etc. BLACK Specify:	n Indian, Black,
filed within 72 hours after death with the Maryland I Hygiene. do ther than "natural", or items 23a or 28a-f shu, the Medical Examiner must be notified at once e Completed by Funeral Director	15. Decedent's Education (Specify only I	highest grade completed) 16a College (1-4 or 5+)	a. Decedent's Usual Occupation during most of working life. D	(Give kind of work done	16b. Kind of Business/Inc	
uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle, N		
E = 5 + 0	LEON SMITH			MARIE HARDY	iarasi, sarriams,	
id Men is mar tic eve	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street a	nd Number or Rural Route Num		Zip Code)
nd 2 sho alth and m 27 is aumati	CORNELIA MIMS /		616 ELMLEY A	AVE. BALTO.	MD. 21213 20c. Location - City or To	own State
permit. Pages I and 2 should be Department of Health and Ment Important: If tiem 27 is markingury or other traumatic even To B	1 Name of the specify:	Removal from State GREE	atory of other place)	JUNE 15, 2	006 BALTO.	
permit Depar Impo injury	2 on ture of Funeral Service Licenses	The Marie 14	22. Name and Address of CALVIN B.	SCRUGGS FUN	ERAL HOME	
hysician /Medical xaminer	23a Part I. Enter the disease, or complice failure. List only one cause on each Immediate Cause (Final disease a. H)	line. ypertensive Atherosclero		ch as cardiac or respiratory arre		Approximate Interval Between Onset and Death
	Sequentially list conditions, b	e to (or as a consequence of):				
ted ansit Examiner	events resulting in death) Last	ne to (or as a consequence of):				
cate be executed physician and he burial - transit		AMENDED item#20b,p	erFH,G856,6/16/06	TT		
the death certificate be expended for use as the burial Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand Live birth Pregnant at time of death Unknown	2 Fetal death 3 5 Other (Specify)	Ectopic pregnancy	23d. Date of delivery Month Da	y Year
S or at						,
the deat by the at tached for	Part II. Other significant conditions	ontributing to death but not result	ting in the underlying cause giv	en in Part I 23e. Did to	bacco use contribute to the	
ires that the deat signed by the at be detached for ad by Physical	Part II. Other significant conditions of Cirrhosis of Liver	ontributing to death but not result	ting in the underlying cause giv	1 Yes	No 3 Proba	e cause of death?
The law requires that the deat are has been signed by the at age 2 should be detached for ompleted by Physical		ontributing to death but not resul	ting in the underlying cause giv	1 Yes	an sy med? No 3 Proba	bly 4 Unknown
inn: The law requires that the dear certificate has been signed by the at ector, page 2 should be detached for Be Completed by Physi	Cirrhosis of Liver		26 Place c	1 Yes 24a. Was autop perfor 1 Yes f Death (Check only one)	an y 24b Were auto prior to co death? 2 No 1 V Yes	bly 4 Unknown
nding Physician: The law requires that the deat the thin the ris certificate has been signed by the at the funeral director, page 2 should be detached for ion: To Be Completed by Physician:	Cirrhosis of Liver	spital: 1 Inpatient 2 ER	26 Place c //Outpatient 3 ✓ DOA D. Time of Injury 28c. Injury	1 Yes 24a. Was autop perfor 1 Yes Perfor Yes F Death (Check only one)	an 2 No 3 Proba 24b Were auto prior to co death?	bly 4 Unknown
ital or Attending Physician: The law requires that the dear urs after death ray Director: After this certificate has been signed by the at ittled in by the funeral director, page 2 should be detached for ertification: To Be Completed by Phys.	Cirrhosis of Liver 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	spital: 1 Inpatient 2 ER. 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury . At home	26 Place c //Outpatient 3 ✓ DOA D. Time of Injury 28c. Injury	1 Yes 24a. Was autop perfort 1 Yes 1 Death (Check only one) 1 Nursing Home 5 at Work? 28d Describe 28d Describe	No 3 Proba 2 No 3 Proba 24b Were auto prior to co death? 2 No 1 V Yes Residence 6 Other now injury occurred	bly 4 Unknown psy findings available mpletion of cause of 2 No
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Ing Physician: The law requires that the d After this certificate has been signed by the funeral director, page 2 should be detached on: To Be Completed by Phy	Cirrhosis of Liver 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a Certifier 1 Certifying Physiciar (Check only one) 2 Medical Examiner: Case 29b. Signature and title of certifier	spital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home (Specify) 1: To the best of my knowledge, on the basis of examination and/ound manner stated.	26.Place of 26. Place of 27. DOA 0. D. Time of Injury 1. 28c. Injury 1. Yes, farm, street, factory, office but death occurred at the time, date or investigation, in my opinion, 29c. License O.C.N	1 Yes 24a. Was autop perfor 1 Yes 1 A Yes 14a. Was autop perfor 1 Yes 15a. Yes 15b. Yes 16b. Yes 17b. Yes 17	an y 24b Were auto prior to co death? 2 No 1 Ves Residence 6 Other now injury occurred Street and Number or Ruraltate)	le cause of death? bly 4 Unknown ppsy findings available mpletion of cause of 2 No al Route Number, City d. cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician June 13, 2006 2:20 P Michael R. Thomas, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice **Baltimore** 8. Date of Birth (Month, Day, Sep. 8, If Under 1 Year | ff Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1937 1**X** M 2□ F 68 Maryland 216-34-4762 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other traumatic event, the Medical Examiner must be notified at X Yes 2 No Directo N/A **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1707 Wilkens Avenue 21223 United States or items 23a Funeral 12. Was Decedent Ever in U.S.
Agned Forces?
12 Yes 2 No 1958—
If Yes, Give
Year or Dates: 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes X No White Specify. à 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales Manager Furniture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Thomas Teresa Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 2804 Michigan Ave., Baltimore, MD 21227 Michael R. Thomas, Jr. Son 20b. Place of Disposition (Name of MD or Vet erains or Cemetery 20c. Location - City or Town, State 20a. Method of Disposition ō Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) = 5 important: if eny injury or 6-16-2006 @ Crownsville Crownsville, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final oul monoy desease **Physician** a Chronic Obstructive disease or condition resulting in death) ICUB /Medical Due to (or as a consequence of) nodules and masses Examiner Muhan Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or are a consequence of Physician/Medical Examiner sician and burial-transit Due to (or as a consequence of) the ettending physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? Month 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ŏ this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0035712 Housen MD. completed cause of death (Item 23a) (Type, Print) Joseph Richey Hospice Balk MD 21201 28 N 31. Date filed (Month, Day, Year)
JUN 1 6 32. Reistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 2010 p M 14 AUDREY DENISE WOODFOLK June 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD CO BELATE If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 1 F Yrs. 27 **Director** 215-72-4531 1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r then "neturel", or iteme 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND HARFORD CO ABERDEEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 74 MOYER DRIVE U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2XXVo Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed with! Hygiene. HEALTH CARE 12th grade NURSE marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fand Mental F MABEL J. WOODFOLK JIMMIE L WOODFOLK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel J. Woodfolk/Mother 74 Moyer Dr., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tXOBurial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Depertment of Important: If eny injury or 2002. 4 ☐ Donatjon 5 ☐ Other (Specify) HARFORD MEMORIAL GRDNS 06-19-06 ABERDEEN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each lig. chas Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 hours after within 24 hours a To the Funeral I Medical 29a Certifier 1 Contining Physician: To the best of my knowledge death occurred at the time, date and plane and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title ocertifier 29c. License number 29d. Dale signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** steven white 2006 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore 5. Social Security Number Hospital Baltimore itu If Under 1 Year If Under 24 Hrs. 8. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9/30/1955 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 MM 2 □ F 212-58-549 USual Residence of Decedent Director 30 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location rthan "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 XYes 2 No Director MD altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any njury or other treumatic event, the Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) ucille Date Date 20c. Location - City of Town, State Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State L'altimore, 4 ☐ Donation 5 ☐ Other (Specify) 19/06/ 22. Name and Address of Facility
Variable Comments of Facility
5151 Pato. NAT P. Ke, Battore, MD 21. Signature of Funeral Service Licensee arcono 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician reumo cystic anni week /Medical Due to (or as a consequence of): Examiner Immunode Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner thet the death certificate be executed inding physicien end use as the burial-transit Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. sete has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21X No this certificate 1 ☐ Yes 2 No Vital 1 Yes After this certifice funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02 12 indy 30. Name and address of person who comolet a cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN16

2006

ORIGINAL

MD

32. Paristrar's Signature

Amended Item 2 per Physician 06/14/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Maryof Dath, 2006 3. Time of Death **Physician** Mary Ann Adams 4:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5068 Amantea Way Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Aug. 28, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 TN **Funeral** 1 M 2 XF 76 256-38-7560 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Modical Examines must be notified at MD Carroll Sykesville 1 ☐ Yes 2€No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5068 Amantea Way 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Office Clerk Library of Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Stone Burgess Hester Ann Dunivant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Sylvester R. Adams 5068 Amantea Way Sykesville, MD Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages i Department of P Important: If ite 1XXBurial 2 Cremation 3 Removal from State ō Resthaven Mem. Gardens June 3, 2006 Frederick, MD nation 5 Other (Specify) injury 4 10 21. Sid atur of Funeral Service License Burrier-Queen Funeral Home & Crematory 1212 W. Old Liberty koad Winlield, M 21784 n. En er the disease, lock, or heart failure. L mplications Approximate Interval Between Prest and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Im ediate C use (Final dis ase or ondition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 2 6 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ē 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical e and title of certifie 29b. Signatur

death certificate be executed P.O. I Division of Vital Records, Attanding Physician: death. 9

the Maryland

death with

72 hours after

filed within

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Baltimore, Maryland 21215-0036

10

State Registrar 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) Center St. Westminster

		1 - For State Registrar	State of M	laryland /		artmen <i>rtificat</i>			and M		giene leg. No.	006	19092
		1. Decedent's Name (First, Middle, Last,								2. Date of Dea	ith		3. Time of Death
Physic /Med		Helen Frances	Addisc	n						May 29,	2006	Year	2:25 A M
Exam		4a. Fecility Name (If not institution, give				4b. City,	Town, or	Location o	f Death		4c. Co	unty of Death	1
		Solomons Nursing	Center			Solor	nons				C	alvert	•
Funera Directo		214-12-7592		ge (In yrs. last 94	birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Birti (Month, Day Dec 7	1911	9. Birth Ohi	nplace (State or Foreign untry) .O
pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
faryli sho	ō	Maryland Calvert		Solon									1 ☐ Yes 2 ☐ No
or 28e-1	Funeral Director	10e. Street and Number 13325 Dowell Road				10f. Zip	Code 688				10g. Çitizer Unite	of What Cou	
ath v	rai												
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Maryland 21215-0036 Id 2 should be liled within 72 hours alt Ith and Mental Hygiene. If Is marked other than "natural", or reteumatic event, the Madical Experi		19a. Informant's Name/Relationship (7) Dorothy French – (I Route Numbe	r, City or To	own, State, Z	ip Code)
Baltimore , permit. Pages 1 ar Department of Heal Importent: If item sany injury or other		20a. Method of Disposition		20b. Place	of Dispo	sition (Nan	ne of		20 8	ate	20c. Locat	ion - City or 1	Town, State
TO ages ant of it: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place ceme Metro	opol:	natory or o itan	ther place Fune	®May raI¦S	ervi	ce ce	Alexa	ndria	Virginia
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Hospitel or 24 hours afte Funeral Directory filled in	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes ner: On the basis and manner s	of examination	dge, death and/or in	occurred vestigation	at the tim	e, date an	d place, a	and due to the d ad at the time, d	ause(s) and late and pla	d manner as ace, and due	stated. to the cause(s)
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,		30. Name and address of person who co	ompleted cause of	death (Item 23	a) (Type.	Print)							
6		Manoj Mathur MI	•				305	Princ	e Fr	ederick	MD 2	20678	
S	tate	31. Date filed (Month, Day, Year)	32. Regist	trag Signature									-
Regis	trar	MAY 3	1 2000	Maria	K	Rose	rate B)					

Robert Joseph Butler

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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-b ₁₀		4a Facility Name (if not institution	•			b. City, Town, or	Location	of Death	May 31,		c. County o	f Death		
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Funeral		5. Social Security Number	6 Sex 7.	Age (In yrs last bir	thday)	If Under 1 Year Months Day	_	er 24Hrs. Min.	1			Foreign	place (State	
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Baltimore, permit. Pages I ar Department of Hee important: If ite		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from	State crema	tory or othe				Date		Location -	-		
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Baltimore, MC permit, Pages I and 2 sl Department of Health ar Important: If iten 27 injury or other trauma		21. Signature of Funeral Service	OB lux	Kon O		ame and Address								
Physician		23a. Part I. Enter the disease, or		sed the death. Do n					-				Approximate	e Interval
/Medical Examiner		failure List only one cause Immediate Cause (Final disease		arrythmia									Between Or Dear	
A		or condition resulting in death)	Due to (or as a co	onsequence of).										
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Hospit 24 hour Funer sely fill		292 Certifier	ysician: To the best of	of my knowledge, de	ath occurre	ed at the time, da	ate and pla	ace, and du	ue to the cau	ıse(s) ar	nd manner a	as started		
Division of Vital Records, P.O. Box 6 To the Ilospital or Attending Physician: The law requires that the death cent within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical		miner: On the basis of and manner stat		investigatio	on, in my opinion	, death oc	curred at t	he time, date	e and pla	ace, and du	e to the d	cause(s)	
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		Valore	WW)			O.C.I	VI. ∟ .			Jun	e 1, 200	б		
CR		30. Name and address of person Laron Locke MD. As	who completed cause Ssistant Medical I	, ,	1 Penn S	Street, Baltir	npre, Mi	D 21201	1					
S	tate	31. Date filed (Month, Day; Year)	J32 Pagi	etrarie Signature										
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Gary Allen Butler May 30 2006 10:45A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 22, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F Maryland 53 Yrs Director 216-60-9107 Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.

and: If item 27 is marked other than "natural; or items 23a or 28a-f ahow and it item 27 is marked other than "natural; or items 23a or 28a-f ahow ury or other traumatic event, ite Mudical Exprises that 1 Yes 2 No Frederick Frederick Maryland Direct 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 25 Winchester St., Apt. 1 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Marned altimore, Maryland 21215-0036 1 Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) brick mason construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Hoy Earlston Butler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick, MD 21703 Dorothy M. Butler/ mother 7101 Canterbury Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If its eny injury or ot ong injury or ot 1 Burial 2 Cremation 3 Removal from State A11 County Cremation | 6/4/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lice atharise 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cance Immediate Cause (Final Kenal **Physician** MO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedate cause. Enter Underlying Cause (Disease or injury Due to (or as a sur sequence of): The law requires that the death certificate be executed attending physicien and I for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part fl. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate 1□ Yes No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this nerel Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifie and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 003/058 5-31-06 MJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10200 Coppermine Rd. Genè F. Ashe Woodsboro, MD 21798 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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			1 - State of Maryland		artment of Hortificate of L			giene Reg. No. 20	06	9	95
			Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of	Death
	Physicia /Medic		Donald V. Brand				June		006	2:23	РМ
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of [Death	4c. County			
			Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	et hiethelaul	Elkton If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	Ceci		lace (State o	r Formian
	Funeral Director		092-20-3321 1XM 2 F 79		Months Days		Min. Jan. 22	y, Year)	Cour	Ny	i i oraigii
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	show	_	10a. State 10b. County 10c. City,	Town or Lo	ocation				1	0d. Inside Cit 1 ☐ Yes	•
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	r Iten	표	Armed Forces? 1 □ Never Married 2 Married 1 Marrie		it Yes, specify Cubai	n, Mexican, F	uerto Rican, etc.)	Bled	k, White,		
3	al', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2XX No	Specify:		Specify	Whi	te	
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1)	f Hearlitem		20a. Method of Disposition 20b. Pla	ce of Dispo	osition (Name of matory or other place		-08-2006	20c. Location -	City or To	own, State	
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۵	89 = 9		Kichard L. Goodie				., Rising		219	911	
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			Jerstey K. Margher 19			~		513	1200		
	10+ I VR		30. Name and address of person who completed cause of death (Item			, Dis	ing Sun, M	ID 2191	1		
		ate	Joseph K. Weidner, Jr., MD 10 31. Date filed (Month. Day, Year) 32. Registrar's Signatu	ure 🖊	wal wal	, no	crig suri, IV	2171			
	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signate 5 2006	400							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician May 2006 3:08 P Judith Ann Butler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Ctr. Clinton Clinton Nursing & Rehab. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Months Days 1 ☐ M 2 🗓 F Director 64 31, 1941 Wash.. 577-56-8333 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if Item 27 Is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event. It is Modical Exactinat part roughed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Maryland Clinton Prince George's Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 United States 9211 Stuart Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married African 1 Yes Sive 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Labor Elementary/Secondary (0-12) College (1-4or 5+) Government Paralegal 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Ewell Thomas Butler ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 - 26th Ave., Temple Hills, MD Michelle E. Butler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park 6/2/2006 Landover, MD 21. Signature of funeral Service License 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE. Wash., DC 20019 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate vause (Final Atherosclero Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 Year Uterine Cancer if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) hed f 1 ☐ Yes 2 👿 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 🗌 Yes 2**/2** No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 417 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident i after death filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd., #101, Ft. Washington, MD 20744 M.D. Michael Sidarous, 31. Date filed (Month, Day, Year) State JUN 0 5 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

06-03733 Patricia Bennett

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	of Death		Reg	g. No. 201	36 130		
Physicia edical Exami		1. Decedent's Name (First, Mid Patrica E		· ·			2. Date of Death Month June 1, 200	Day Year	3. Time of Death 0952 hrs		
		4a Facility Name (if not institut			4b. City, Town, or Lo	ocation of Death	Julie 1, 200	4c. County of Deat			
		Southern Maryland I			Clinton		_	Prince George's			
Funeral Director		5. Social Security Number		yrs. last birthday	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	_	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign			
Director		577-80-0419	1 M 2 XF 4	8	Yrs.		2/2/5	58 0	ountry) DC		
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lanylar 8a-f s at on	Director	10e. Street and Number			10f. Zip Code	. –	10	g. Citizen of What Cou	ntry?		
with the Maryland ms 23a or 28a-f show any be notified at once,		7004 Targ	luin Ave		20748			USA			
h with	Funeral	11. Marital Status 1 Never Married 2 🔀	12. Was Decedent Ever		Was Decedent of Hispa If Yes, specify Cuban, N			14. Race - Amer White, etc.	ican Indian, Black,		
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11215-0036 Id be filed within 72 Aental Hygiene narked other than '	ပိ	17. Father's Name (First, Middl Clifton Joh			18	Mother's Name Elean	(First, Middle, Ma Or MCDa	aiden Surname) aniel			
2121 hould be fill and Mental I is marked tite event, i	To B	19a Informant's Name/Relation		19b. Ma	ling Address (Street a	and Number or R	ural Route Numb	ner City or Town State	Zin Code)		
		Ronald Alona	zo Bennett	I	04 Tarqui						
re, MC s I and 2 s of Health a If item 27		20a. Method of Disposition	on 3 Removal from State		position (Name of ceme other place)	* 1		20c. Location - City or			
Pages ment o tant: I		4 Donation 5 Other			ale Park	6/	9/06	Riverdal	.e ,Ma		
Baltimore, permit. Pages I ar Department of Heg Important: If ite injury or other tr		21. Signature of Funeral Service	e Licensee	2	TOMPA BESSME	Euary	Service	e,P.A.			
Physician	U.,	23a. Part 1 Enter 1 e disease, o	or complications that caused the		1409 Fair				MQ ZU / Z I Approximate Interval		
/Medical		failure. List only one caus Immediate Cause (Final diseas	se on each line.		, ,		, , , , , , , , , , , , , , , , , , , ,		Between Onset and Death		
Examiner		or condition resulting in death)									
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		23b Was decedent pregnant in past 12 months?	1 Live birth Pregnant at time	of death	Fetal death 3	Ectopic pregnar	псу	Month [Day Year		
Box 687 he death certific the attending p	Physicia	1 Yes 2 No 9 🗸 U		or death 5	Other (Specify)				i		
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ital Recorician: The law rector, page 2 sh	Com						perform 1 V Yes 2		es 2 No		
tal Rec ician: The certificate ector, page	Be (25. Was case referred to medic examiner?	Henrick		100	Death (Check o					
of Ving Physical Conneral dir	٥	1 Yes 2 No 27. Manner of Death	28a Date of Injury	2 ER/Outpati	511. 0 5011	4 11d15/11g		esidence 6 Other	·:		
Division of Vital Records, tal or Attending Physician: The law require is after death all Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be all or the funeral director.	Certification:	1 Notinal	(Month, Day, Year)			s 2 No	204 0030100110	w figury occurred			
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Division pital or Attentours after deatheral Birector:	erti	4 Homicide det	dermined (Specify)				or Town, Sta	ite)			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use at			Physician: To the best of my kno								
To the within To the comp	Medical	2 ✓ Medical Ex 29b. Signature and title of certif	taminer: On the basis of examination and manner stated	ard/or investi	gation, in my opinion, d			nd place, and due to the 29d Date signed (Mor			
	_	(In A	P NA DO	0/ 1 -	O.C.M.			June 2, 2006	iiii, Day, rear)		
1		30. Name and address of person	on who completed cause of death	(Item 23a)							
20/			ssistant Medical Examine		n Street, Baltimore	e, MD 21201					
	ate	31. Date filed (Month, Day, Year	2. Registrar's Si	gnature	K)						
Regist	rrair	JUN 0 6 2	006 Slace A	AS ASSESSED							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Scott Belskie 26, 8:50 PM May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6155 Hallowing Point Road Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 1.□M 2□F 48 Director 153-52-1170 May 2, 1958 Canada the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wedical Examiner must be notified at Maryland Calvert Prince Frederick 1 Yes 2 XNo Director 10f. Zip Code 20678 10g. Citizen of What Country? United States 10e. Street and Number 6155 Hallowing Point Road death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) cabinet maker construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Evelyn McManus Albert A. Belskie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 0 6 7 8 MD 19a. Informant's Name/Relationship (Type, Print) Carol Belskie - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) May 31 Data 2006 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Funeral Service Alexandria Virginia 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Important: any injury o 22. Name and Address of Facility Rausch Funeral Home 20676 21. Signature of Funeral Service Licensee 4405 Broomes Ts. rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hereine failure disease or condition resulting in death) Zmuth /Medical Due to (or as a consequence of): Examiner toxic hepatihs 2 marchs of unknown course Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed inding physician and use as the burial-transl that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ wentle cell lymphana 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed peer allogeners stem ced transplantation complicated by veno occione 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No disease of the live 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 30 2006 D56024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Abbott, MD 110 Hospital Rd. Prince Frederick MD 20678 31. Date filed (Month, Day, Year) 32. Registrans Signature State Registrar 2006

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	rland ow at		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation		10d. Inside City Limi			
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	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other treumatic once.		John Blom		205			ock Ave.,				
Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3		State	cemetery, cren	sition (Name of natory or other pla	· 1		20c. Location - (-	
altin	mit. P partme porten r injuri		*4 □Denation 5 □ Other (Spe 21. Signalule of Funeral Service Lice		K		e Cemete	ery 6// ess of Facility Th		KOCKVILI e Funera	e Ce	entre, NY
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			23a. art1. Enter the disease, or co shock, or head failure. List or	mplications that only one cause on the								Approximate Interval Between Onset and Death
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/06 Box	death c a atten d for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live I 4 ☐ Pregi	ointh 2 ☐ Feta nant at time of o	al death 3	Ectopic pregnancy Other (specify)	у		23d. Date Mon		ry Day Year
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2 5	Attending Physicien: The law requires that the death certif rdeath. sctor: Atler this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions	s contributing to d	eath but not res	sulting in the ur	nderlying cause giv	ven in Part I.		_		e cause of death? ably 4 □Unknown
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lenrietta 1-6255 Division	r Attendi er death. rector: A	Certification:	3 Suicide 6 Could no determine	280. Place	e of Injury · At h	lome, farm, str fy)	eet, factory, office		28f. Location (St City or Town	treet and Numbe n, State)	r or Rural	Route Number,
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Blom, Henrietta 90-01-6255 Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	aminer: On the b	e best of my kno asis of examination oner stated.	owiedge, death ation and/or inv	roccurred at the till restigation, in my d	me, date and place opinion, death occu	e, and due to the co arred at the time, d	ause(s) and man late and place, a	ner as sta nd due to	ated. the cause(s)
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S	1116		30. Name and address of person when the state of the stat	o completed cau	se of death (Iter	m 23a) (Type,	Print)	,)	rine	R	20	L. MA
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	Registr	ar	JUN 0 5	2006	2	4						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1150 SIGMUND **BYERS** /Medical 4b. City, Town, or Location of Death 40 County of Death 4a. Facility Name (If not institution, give street and number) Examiner ONSDON If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 213-24-7904 NOV. 4, 1927 Director 78 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 21 No **Funeral Director** WASHINGTON BOONSBORO MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or iteme 23a or 8507 MAPLEVILLE ROAD 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 EX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed withIn 7 h and Mental Hygiene.
7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK STATE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be RALPH STEINMAN BYERS MABEL SIGMUND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Depertment of Heelth and Important: if Item 27 is m any injury or other treum <u>once.</u> ROY J. BYERS/BROTHER 10226 DOWNSVILLE PIKE, HAGERSTOWN, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 | D BOONSBORO CEMETERY ¦6/08/2006 BOONSBORO, MARYLAND 22. Name and Address of Facility 21. Signature o 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. 1 er for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** JAJC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 StOnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 1 Tyes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 ₩atural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown MD 3H-6 Jascem 1126 Dral 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

06-03948 Eric Carnahan

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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		- For State Certific	cate of Death	Re	g. No.)] 0
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		Date of Deat Month		3. Time of Death
edical Exami		Eric M. Carnahan		June 9, 20	06	0755 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of E Baltimore	Death	4c. County of Death	
		Bon Secours Hospital		Alles IO Data of Data	h (A MAID DOGGO (C. Bi-	101
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 2 Months Days Hours	Min	h(MM/DD/YYYY) 9. Bird Foreig	n
Director		214-94-5727 1XM 2 F 33	Yrs.	11/23	/1972 Co	untry) Maryland
ź	H	Usual Residence of Decedent 10a State 10b. County 10c. City, Tow	n or Location			10d Inside City Limits
00 AI			imore			1 X Yes 2 No
ylanc n-f sh	힑	10e. Street and Number	10f. Zip Code	1 10	g Citizen of What Cour	
ith the Maryland 23a or 28a-f show any notified at once.	Director	36 South Schroeder Street	21223		USA	
ith th		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin	2 (Specify Yes or No.		can Indian Black
ath w	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, P		White, etc.	our maint, black,
her de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: V	Thite
5-0036 Within 72 hours after death with the Maryland Iygie with 172 hours after death with the Maryland other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	à	15. Decedent's Education (Specify only highest grade completed) 16a	a. Decedent's Usual Occupation (Give kin		16b. Kind of Business/I	ndustry
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O36	E	2	Accountant		•	State Govt.
5-0 iled v Hygir I other		17. Father's Name (First, Middle, Last)		Name (First, Middle, N	- /	
21215-0036 Muld be filed within 7 Mental Hygiene marked other than	Be	Richard M. Carnahan 19a. Informant's Name/Relationship (Type, Print)		Louise Raw		7 0 1)
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiewith tr. fritem 27 is marked other than "natural", other traumatic event, the Medical Examiner	٩	Richard M. Carnahan	9b Mailing Address (Street and Number 9101 Southmont Lan Fort Myers, FL 33	e. #403 908	per, City or Town, State	, Zip Code)
February Health		20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery, atory or other place)	Date	20c. Location - City or	Town, State
Pages ent of nnt: I			Lincoln Cemetery	6/15/2006	Brentwood,	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral ervice Licenses	22 Name and Address of Earthty			
00 % 2 4 13		and the	Fort Lincoln Fur 3401 Bladensbur	g Road, Br	entwood, MI	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as care	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Salicylate intoxicat	tion			Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				1
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cuted ind transit	Exa	events resulting in death) Last Due to (or as a consequence of):				
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760, ficate be ex g physician t the burial	Jed	IF FEMALE: 23c. If yes, outcome of pregnance	·		23d Date of delivery	,
3876 rtificat ing phy as the	an/l	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic p	regnancy		Day Year
Box 68 death certif the attending	sici	4 Pregnant at time of death	5 Other (Specify)			
. BC he de y the	Physician/Medical	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part	23e Did to	bacco use contribute to	the cause of death?
, P.O. res that th signed by	β	Tarkii. Othor significant conditions	and in the didenting eadse given in a are	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2 ✓ No 3 Prob	
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OFC aw re	gle			autop perfor	sy prior to a	completion of cause of
tal Rec tian: The certificate	Completed			1 Yes		es 2 No
Division of Vital Records, tal or Attending Physician: The law requirt safer death as after death all Director: After this certificate has been sited in by the funeral director, page 2 should be an up to the funeral director, page 2 should be as a constitution of the funeral director.	Be	25. Was case referred to medical examiner?	26.Place of Death (C			
f Vi Physi er this ral dir	ဥ	1 Yes 2 No	Outpatient 3 DOA Other 4 1 b. Time of Injury 28c. Injury at Work?	Nursing Home 5	Residence 6 Other	<u> </u>
n of \ding Ph; h, After tl	on:	1 Moturel (Month, Day, Year)	1 You 2 1	la .		
Sior Attend r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home	nk ' ' ' ' ' ' ' ' '	bubject i	ngested 250 as Street and Number or Ru	•
Divi	Certification:	X Suicide Could not be determined (Specify)	; faith, street, factory, office banding, etc.	or Town, S		rantodio Hamber, Ony
lospit 1 hour there		29a. Certifier	death occurred at the time, date and place		e(s) and manner as star	ted
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	one) 2 Medical Examiner: On the basis of examination and/o	•			
To To	Mec	29b. Signature and title of cert/fier	29c. License number		29d. Date signed (Mo	nth, Day, Year)
		MINAIN	O.C.M.E.		June 10, 2006	
		30. Name and ad ress of person who complete cause of death (Item 23a	a)			
CR		Susan Hogan MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MI	D 21201		
	tate	31. Date filed (Month, Day, Year) Registrar's Signature 111 3 7006	last.			· - ·
Regis	trar	JUN 1 3 2006 Kleen	you			
		•				

Amended Item 23a Part I per Physician 06/02/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:35P ^M Leonard Walter Charles June 1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13812 Unionville Rd. Mt. Airy Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 225-26-3000 Yrs. 82 17, 1924 Kentucky Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Frederick Mt. Airy Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13812 Unionville Rd. 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other traumatic event, the Madic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) truck driver construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Walter Charles Sr. Velva Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tena E. Charles/ wife 13812 Unionville Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 6/2/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signal r of Fune al Service Licensee 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final morths **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Renal Cell Carcinoma if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s 2 No 1 Tyes To the Hospitel or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 - Pending 1 Tes 2 No death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fi investigation 2 Accident the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of pertition D26499 WIL 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Elsen & Sparte JUN 0 2 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State	of Maryland / D				•	
			State	•	Certificate			211116	19103
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j.	/Medic Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Tow	n, or Location of Death		4c. County of Deat	h
	LAGITITI	٠.	Ft. Washington Hospital		Ft. Wa	shington		Prince Georg	e's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bird	Months Da		8. Date of Birth (Month, Day, Y	'ear) 9. Birtl	nplace (State or Foreign untry)
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	land land	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
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	r 28s	irec	10e. Street and Number		10f. Zip Cod	le	100	g. Citizen of What Co	untry?
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	r dea	ner	11. Marital Status 12. Was D Armed	ecedent Ever in U.S. Forces?	13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Suban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
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g	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
yla	Ment Ment arked atic	၉	Austin Hobart Clark			Mary (
Maryland 21215-0036	12 sh and c le m		19a. Informant's Name/Relationship (Type, Print) Virginia Sanchez Clark / Wif			eet and Number or Rui Lane Oxon Hil			(ip Code)
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Division of	or Attendater deat Director: in by the	Certification	determined 289. Pl	ace of Injury - At home, fa ulding, etc. (Specify)	.m, street, factory, off	ice	City or Town,	et and Number or Ru State)	ral Route Number,
	Hospital 24 hours a Funerel I		29a. Certifier 1 Certifying Physician: To	the best of my knowledge	death occurred at th	e time, date and place	and due to the caus	se(s) and manner as	stated
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medicai	(Check only 2 Medical Examiner: On th	e basis of examination and anner stated.	d/or investigation, in n	ny opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	1 N	ense number	0 0	I. Date signed (Month	
			NA.11. A	made	411	10 400	46	6-1-3	2006
0	16)		30. Name and address of person who completed o	ause of death (Item 23a) ((Type, Print)				
	(4)		Mirza Alikhani MD 11711 I: 31. Date filed (Month, Day, Year)	ivingston Road	Ft. Washingt	on, Maryland	20744		
	Sta Registr		JUN 0 5 2006	. Registrar's Signature	route				

		•	1 = For State Registrar	,	Certificate of	Death	R	eg. No.	0 13107
			1. Decedent's Name (First, Middle, Last,)			2. Date of Deat Month	th Day Yes	3. Time of Death
	Physicia /Medic	-	Homer Franklin	Cash			June	3 , 2006	3:05 p M
)	Examin		4a. Facility Name (If not institution, give			r Location of Death		4c. County of D	
			Southern Marylan	<u> </u>	Clinto		0.0		George Co.
	Funeral Director		5. Social Security Number 6. Security Number 430–20–8311 Usual Residence of Decedent	7. Age (In yrs. last b.	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Jan. 1	Year)	Birthplace (State or Foreign Country) rkansas
	fand ow		10a. State 10b. County	10c. City, Tov	n or Location				10d. Inside City Limits
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	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
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p	be filed vital Hygie od other if	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)	
<u>ya</u>	should be and Mental marked o	ဥ		ash		Pearl	Quinn		
, Maryland 21215-0036	12 that		19a. Informant's Name/Relationship (7) Alan Cash / Son	_	b. Mailing Address (Street B512 Ridgelir				
ore	ges 1 and it of Healt if item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	l camet	of Disposition (Name of ery, crematory or other plac		Date	20c. Location - City	or Town, State
Ĕ	Pages ment of I ant: If its ury or o		4 Donation 5 Other (Specify)	Maryl	Land Veteran	Cem. 6-9-	-06	Cheltenha	m, Maryland
Baltimore,	permit. Pag Depertment Importent: I eny injury o		21. Signature of Funeral Service Licens	ee / / /	22. Name and Addre Alexander	ss of Facility S. Pope I	Tuneral	Homes, P.	Α.
	0020 d		melle M.	Hellet	5538 Marl	oro Pike	Forestv	ille, Md.	20747 Approximate
П			23a. Part 1 Enter the disease, or complishock, or heart failure. List only o	ne cause on each line.	not enter the mode of dylr	ig, such as cardiac d	respiratory arr	951,	Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	store 91911	9			
	Examiner			Due to (or as a consequence	e wolved home	shhere is	adout		
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (pr/as a consequence	of):	spire 1	19101		
	od ansit	Examiner	Cause (Diseese or injury that initiated events	Hyper Ten:	sian				
ó	en ar en ar rial-tr		resulting in death) Last	Due to for as a consequence	9 of):				
68760,	icate be executed physicien and s the burial-transit	Medical		d			.		
	artifica ing ph e as t		IF FEMALE:						
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P.0	that the de ned by the detached		Part II. Other significant conditions co	ntributing to death but not resulting	in the undertying cause giv	en in Part I.	23e. Did tol	bacco use contribute	e to the cause of death?
of Vital Records,	uires sign	d by	Coronary Ar	tera discare	_		1 🗆 Y	es 2 No 3	Probably 4 Unknown
5	w requir been si should	ete					24a. Was a	n 24b. Were	autopsy findings available
Re	The lascate has	Completed		<u>V</u>			autops perform	med? prior death	to completion of cause of
<u>a</u>		ပိ	25. Was case referred to medical			26. Place of Death	1	A	′es 2□ No
>	Physician: r this cenific ral director,	To B	avaminar?	Hospital: Inpatient 2 ER/C	Outpatient 3 DOA Oth	00		ence 6 Other (S	ipecify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury Wor	y at k?		ow injury occurred	,
Sio		catl	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No			
Division	P S S	Certification:	4 Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office		City or Town	reet and Number of n, State)	Rural Route Number,
	Hospita 4 hours Funerel	edical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at the tir and/or investigation, in my o	me, date and place, a pinion, death occurr	and due to the coed at the time, d	ause(s) and manner ate and place, and	as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and MO	29c. Licens	e number		9d. Date signed (M	
	<u> </u>) [full]	11/2.	000	16220C		June 5	2006
2	(10) Na		30. Name and address of person who o	ompleted cause of death (Item 23a	(Type, Print) 7503 Surratt	s Road C1	inton,	Md. 20735	-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	ar	JUN 0 6 2006	place 1 1					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Frederick Robert Cousar

Physicia		1- For State Registrar	Certificate of	' Death	F	Reg. No.	401	10 131		
cal Evamin	-	Decedent's Name (First, Middle,Last)			Date of De Month	ath Day	Year	3. Time of Death		
al Examin		Frederick Robert Cousar 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	June 1, 2	006	County of Deat	1735 hrs		
		4601 Eastern Avenue		Hyattsville	Deall		ince Georg			
Funeral			yrs. last birthday)	If Under 1 Year If Under	24Hrs 8 Date of B			rthplace (State or		
Director		578-70-4407 1XM 2F 53	Yrs	Months Days Hours	Min. 08/05	/1952	Forei	gn puntry) DC		
any	ŀ		: City, Town or Locati	on				10d. Inside City Limits		
nd show	۲	DC W	Vashington					1 X Yes 2 No		
with the Maryland us 23a or 28a-f show any be notified at once.	Director	10e. Street and Number		10f. Zip Code		10g. Citize	en of What Cou	intry?		
the \		1218 Owen P1. NE		20002		U.S.	Α.			
n with	Funeral	11. Marital Status 12. Was Decedent Ever		s Decedent of Hispanic Origin		0- 1		rican Indian, Black,		
or ite	Ē	1 Yes 2 X	No	es, specify Cuban, Mexican, I	Puerto Rican, etc.)		White, etc.			
s after ral".	<u>S</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specify:			pecify Blac			
Pages and 2 should be filed within 72 hours ar ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		t's Usual Occupation (Give ki ost of working life DO NOT u		16b. Kir	nd of Business	Industry (Industry		
should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f shr airie event, the Medical Examiner must be notified at once		12	Journ	eyman-Craftsm	an	Pre	ss Pri	ntino		
d with	탉	17. Father's Name (First, Middle, Last)			Name (First, Middle,					
rtal H ked c	B B	Bennie Cousar		Cleo	Johnson					
permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygienc Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examining.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Numb	er or Rural Route Nu	mber, City	or Town, State	e, Zip Code)		
d 2 sh Ith an n 27 i		Harnethia Cousar/Wife	1218	Owen P1. NE,	Washington	ı, DC	, 20002	2		
f Heal		20a. Method of Disposition 1	20b Place of Disposi crematory or oth	ition (Name of cemetery, ner place)	Date	20c. Lc	cation - City or	Town, State		
Page:				In Cemetery	06/10/06	Bre	ntwood	MD		
mit. partm ports	ı	21 Signature of Funeral Service Licensee	22. N	ame and Address of Facility						
2 9 E E	-	eliane a Coppeller		01 Bladensbur				eral Home		
ysician Vedical										
caminer	Ì		Between Onset and Death							
	-	or condition resulting in death) Due to (or as a consequer	nce of):							
	ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequer	nce of):							
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ed sit	G.	events resulting in death) Last	nce of)							
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te be execut tysician and burial - tra	- 1	UNPENDED AMENDED	prognancy			1004	Data of dalling			
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uth certificate be execut ittending physician and or use as the burial - tra	Medical	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? AMENDED 23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fet	ral death 3 Ectopic poer (Specify)	pregnancy					
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		•	For State Registrar	State of Maryland /	Depa Cer	artment of H rtificate of L	lealth and M Death		ene 2 () () {	5 19106
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		VICKI MICHELLE CAL	LAWAY				05/30/	^{'2006}	9:01 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		th	
			SOUTHERN MARYLAND	HOSPITAL		CLINTON			PRINCE GE	ORGE'S
	Funeral		Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		5//-88-1493	JM 2XJF 41	Yrs.			(Month, Day, 10/15/19	64 WAS	HINGTON, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Manyl f ehc	ō	MD DDINGS of	FORCE LC FORT W	IASH1	INGTON				1 X Yes 2 □ No
	28a	Director	MD PRINCE G	EORGE'S	110111	10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or		7716 LANHAM LANE			207//		U	SA	
	death me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13.	20744 Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
21215-0036	within 72 hours after death with the Maryland ane. then 'naturel', or iteme 23e or 28e-f ehow the Madical Examinar must be invittled at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		lf Yes, specify Cuba 1 ☐ Yes 2 💆 No	Specify:	Hican, etc.)	Specify: BL	
ဂ ည	72 hc	eted	15. Decedent's Edu (Specify only highest grad	ication 16	dent's Usual Occupa	ation during most of work	ina 1	6b. Kind of Business	/Industry	
2	Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired IAKER	1)	9	OF TAND	
	filed with Hygiene other the		11TH 17. Father's Name (First, Middle, Last)	11	OFILE	IAKEK	18. Mother's Name	/Circl Middle M	OWN HOME	
Maryland	Q to 0	Be							alden Sumame)	
Ĕ	should be nd Menta marked umatic ev	ို	EUGENE CALLAWAY 19a. Informant's Name/Relationship (7)	una Orient) 16	No. Admilia	a A ddana (Canada	SHIRLEY		City or Town, State,	T- 0- 1-1
Ma	s 1 end 2 should f Health and Men Item 27 is marke other traumatic		KATRINA MARIA CHAN							
	Healt Healt em 2		20a. Method of Disposition	20b, Place	of Dispo	sition (Name of			ON, MD 2()7	
2			1 ☐Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		matory or other plac	1			
altimore,	permit. Pege Department of Important: If eny Injury or ance.		21. Signature of Funeral Service Licens	ee A	KECT	ION CEME'S Name and Addres	ERY: 06/0	6/2006	CLINTON, M FUNERAL HO	D
B	Page 9		121010 P	Moushall	4	308 SUTTI	AND RD	SHALL'S .	FUNERAL HO D. MD 2074	OME 6
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. Do						Approximate
	Physician		Immediate Cause (Final disease or condition	2 .	And	Embolism				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence		74030 NC1-2				
	Examiner		Sequentially list conditions,	h						
	ם ב	iner	cause (Disease or injury	Due to (or as a consequence	a 5f):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence	0:					
8760,	cate be executed physicien and the burial-transit			545 to (51 45 4 551156q45110	o 01).					
587	ficate phys s the	edical		d						
×	eath certifi attending I for use as	M/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Date of de	livery
P.O. Box	The law requires that the death certificate hes been signed by the attending I sege 2 should be detached for use as	Iclan/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
0	res that the de signed by the a be detached f	Phys	9 □ Unknøwn	9⊡ Unknown						
	ss tha	by P	Part II. Other significant conditions co	ntributing to death but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	w require been si should I				<u>.</u>			1 ☐ Yes	s 2,02No 3∏P	robably 4 Unknown
Records,	e law r hes be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u> </u>		5						perform	ed? death?	
Vita	Physicien: The this certificate ral director, pag	Be	25. Was se referred to medical examiner?				26. Place of Death	Check only one	1	
×	Physic this co	္	H_ Yes 2 □ No	Hospital: 1 Impatient 2 ☐ ER/0	Outpatier	nt 3□ DOA Othe	er: 4 Nursing Ho	me 5□Resider	nce 6 Other (Spe	ocify)
U C	ding Ph th. After th funeral	ü	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	. Time o Injury	Work	k?	28d. Describe how	w injury occurred	
<u>s</u>	r Attending er death. rector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	an Blood in			Yes 2 □No	201 1 11 12		
Division of	or A effer Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	iarm, sti	eet, factory, office		City or Town,	eet and Number or R State)	urai Houfe Number,
	e Hospital or Attend 24 hours efter death Funeral Director: etely filled in by the		29a. Certifier , 1 Certifying Phy	sician: To the best of my knowled	ge, deat	h occurred at the tim	ne, date and place	and due to the car	use(s) and manner a	s stated
	To the Hospital or within 24 hours effer for the Funeral Dircompletely filled in I	edical	(Check only 2 Medical Exami	ner: On the basis of examination a and manner stated.	ind/or in	vestigation, in my of	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of gestifier			29c. License	e number	29	d. Date signed (Moni	h, Day, Year)
)			New	MD		Doos	5120	1	14 31 W	6
L	- (4)		30. Name and address of person who co	ompleted cause of death (Item 23a) (Туре,	Drint\			J.	
			21 Date filed (Month Day Year)	1328 Junthem Wer	me.	se sint si	U Washin	y londi 2	0032	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 6 2006	B26 Juhan aver	bra	L.	V			
			3011 0 0 2000	hollow be	1					

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment rtificate	of H	ealth a Death	ind M		iene2 (006	19	10
	Physici		Decedent's Name (First, Middle, Last, James Edward Co							2. Date of Dear Month May	th Day	006	3. Time 6:22	of Death
	/Medio Examir		4a. Facility Name (If not institution, give	<u>_</u>		4b. City, 1		Location o		riay	7	ty of Death		<u> </u>
	Funeral Director		5. Social Security Number 219-01-0349 & & & & & & & & & & & & & & & & & & &	XM 2□F	(In yrs. last birthday) 89 Yrs.	If Under Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Dec. 11		9. Birth	place (State intry) ID	e or Foreign
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 ie marked other than "natural", or items 23a or 28a-f ehow important: If Item 27 ie marked other than "natural", or items 23a or 28a-f ehow any Injury or other traumatic event, the Madical Examinar must be notified at ance.	Funeral Director	MD Worcest 10e. Street and Number 12 34th St., 11. Marital Status	er	Ocean Ci	ty 10f. Zip	1842		sin? (Sne		Og. Citizen of What Country? USA 14. Race - American Indian.			•
2-0036	72 hours after di natural', or item	by	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	Armed Forces? 1 1 Yes 2 N If Yes, Give Year or Dates:	o VWII	1 ☐ Yes 2	Occupa	Specify:		ecify Yes or No- Rican, etc.)	ВІ	ack, White ify: Whi	te	
Baltimore, Maryland 21215-0036	i be filed within ntal Hygiene. od other than "	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Edward H. Collin	College (1-4or 5- 5+	Elect	kind of word DO NOT use rical	Eng-	ineer	r's Name	(First, Middle, I	Elect Maiden Suma		Comp	any
e, Maryla	1 and 2 should be dealth and Ment sen 27 is marked ther traumatics	To	19a. Informant's Name/Relationship (T) John Collins (son. 20a. Method of Disposition	rpe, Print)	993	B E1m	St.	nd Number	r or Rura	ity, Mai		2184	2	
Baltimo	permit. Pages Department of I Important: If Its any Injury or o		1 Burial 2 Commation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		Cape Hen	lopen	Cren	n . (The		Frankf E Fune	ord, ral H	DE	
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):			, such as o			est,		Approxim Interval B Onset an	etween
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Medical E	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. ff yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	of pregnancy 2 Fetal death 3 [ime of death 5 [Ectopic pre	cify)					ate of defivionth	ery Day	Year
	e law requires thi hes been signed je 2 should be de	Completed by F	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	nderlying ca	use give	n in Part I.		1 □ Ye 24a. Was a	n 24b	3 ☐ Pro	babfy 4 [Unknown
of Vital Records,		To Be	27. Manner of Death	lospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	28b. Time o		Othe	r: 4□Nur	sing Hor	autops perform 1 Yes 2 Check only on me 5 X Reside 28d. Describe ho	ned? 2⊠No e) ence 6□0	death? 1 ☐ Yes	empletion of 2 No	cause of
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 X Naturaf 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, str	М	1 🗆 Y	es 2 🗆 N		28f. Location (St. City or Town	reet and Nun i, State)	nber or Rur	al Route Nu	mber,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	one)	sician: To the best of her. On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	vestigation,	n my op	inion, deat	d pface, a	ed at the time, da	ate and place	, and due t	o the cause	(s)
	To I To I	Σ	29b. Signature and title of certifier	a	ms	1	License D Z	L 2	78	4	9d. Date sign	ed (Month,		
8	U 8+/ Sta Registi		30. Name and address of person who con David E. Cowall 31. Date filed (Month, Day, Year)	32. Registra	Head Hospi	tal R	d.,	Salis	bury	/, Md. 2	1801			

ORIGINAL

		4	For State	State	of Maryla			of Hea		lental Hygi	L U	06	19108
			Registrar 1. Decedent's Name (First, Middle	e. Last)			incar	01 00		2. Date of Death	g. No.		3. Time of Death
	Physicia		Charles	D •	(Cram				Month May	28 2	Yeer 2006	1822 ^M
	/Medic		4a. Facility Name (If not institution			JIam	4b. City.	Town, or Loc	ation of Death	TILLY_	4c. Count		1022
	Examin	er	Chesapeake H				I	inthi	cum		Ar	ne Ar	undel
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under Months		Under 24 Hrs.	8. Date of Birth	Year)	9. Birthpi	lace (State or Foreign
	Director		014-12-1678	1 X M 2 □ F	80) Yrs.	Months	Days H	Ours Willi.	Jan. 17,	1926		achusetts
	pr ,		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	ncation					1	0d. Inside City Limits
	anyla ehov	2											1 ☐ Yes 2 TVNo
	Me M	Directo	MD Prin 10e. Street and Number	ce George	5 (Cheverly	10f. Zip	Code		10	og. Citizen of	What Cour	
	a or 2	ă		Ctuant			101. 210	20785		'	USA		,.
	99th 78 23	eral	5817 Carlyle		cedent Ever in	U.S. 13.	Was Deced			ecify Yes or No- Rican, etc.)		ce - Americ	an Indian,
	ther d	Funeral	1 □ Never Married 2 🕅 Mar	ned 1 X Yes	2 No					Rican, etc.)		ick, White, o	_{etc.} Thite
5-0036	urs a	by	3 Widowed 4 Divorced	If Yes, C Year or	Dates: 194	43-46	1 ☐ Yes 2	ZLALNO S	pecity:		Speci	y: W	mice
Ď	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23a or 28a-f ehow the Mudical Examinar must be notified at	Completed		nt's Education est grade completed	f)	(Give	kind of wor	I Occupation	n ng most of work	ring	16b. Kind of E	Jusiness/Inc	dustry
2	thin 19	uple	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT us	e retired)					
7	ygien ygien yer th	ပ္ပ		4		Anal	yst	10	Mother's Nam	e (First, Middle, N	NSA	mol	
<u>n</u>	2 should be filed within 72 hours after deeth with the Marylan and Menial Hygiene. Is marked other then 'natural', or litems 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, George D. Cra							Hutchins		ne)	
3	J Mer nark	၉	19a. Informant's Name/Relation			10h Maili	na Address			ral Route Number,		State Zin	Code)
Maryland 2121	d 2 st th and 7 ier traur		Jerome Richma		al Rep		9			ton, MD		, 01010, 2.6	
	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 ie marked eny injury or other traumatic a once.		20a. Method of Disposition	(101001		. Place of Dispe	osition (Nan	ne of	-		20c. Location	- City or To	wn, State
Baltimore,	ages ont of t: if it	li	1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe		n State	cemetery.cre orest H			6-3-	-2006	Bostor	n ΜΔ	
	artme ortan injur		21. Signature of Funeral Service		I.		2 Name an	d Address of	f Facility	501536C C		i, iui	
B	Per Per Per Per Per Per Per Per Per Per		thingy				Harde	esty F idoelv	uneral Avenue	Home, P.	A. Dis. N	س 214	.01
			23a. Fart1. Enter the disease, of shock, or heart failure. Lis	r complications tha	t caused the de	eath. Do not en	ter the mod	e of dying, su	uch as cardiac	or respiratory arre	est.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Corny one cause or	m	Tun	7.7	7	Com				Onset and Death
	/Medical		resulting in death	aDue t	o i as a cons	sequence of):	un	La		u			
	Examiner		Sequentially list conditions,	b/	ane	rate		Can	ces				
	p =	ner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duet	d (or as a cons	lequelice of).							
	erute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.	- /	and and after						_	
8760,	death certificate be executed estending physicien and of for use as the burial-transit	E		Due	o (or as a cons	sequence on).							
87	physicate to the the the the the the the the the the	Physiclan/Medical		d.									
9 X	eath certific ettending pl	Me	IF FEMALE:	23c. If yes, o	outcome of pre	gnancy			1		23d. D	ate of delive	erv
Вох	eath etten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	e birth 2 F gnant at time o	etal death 3	□Ectopic pr □ Other (sp					lonth	Day Year
P.O.		isi	1	9□ Uni	known								
	law requires thet the as been signed by th 2 should be deteche	by P	Part II. Other significant condit	ions contributing to	death but not	resulting in the	underlying o	ause given in	n Part I.	23e. Did tob	oacco use cor	ntribute to th	he cause of death?
rds	quires in sign	d be				_				1 🗆 Ye	s 2 No	3 ☐ Prob	oably 4 🗆 Unknown
Vital Records,	law require as been si 2 should b	Completed								24a. Was a		. Were auto	ppsy findings available impletion of cause of
æ	o - 0	E								perform	ned?	death?	2□ No
ital	sician: Th certificete rector, pag	BeC	25. Was case referred to medic examiner?	al				26	6. Place of Dea	th (Check only on	θ)		
of V	d is	To	1 ☐ Yes 2 ☐ No	Hospital:	☐ Inpatient 2	ER/Outpatie				ome 5 Reside			y) House
ם	Jing Pl		27. Manner of Death 1 ☐Natural 5 ☐ Pend	(1.4	te of Injury onth, Day Year	28b. Time (28c. Injury at Work?		28d. Describe ho	w injury occu	rred	
Sio	Attending r death. actor: Attel	cat		tigation			М		2 □ No	28f. Location (St		the second	- Bouto Musha
Division	or Attendestleter destlement Director: in by the	Certification:	4 Homicide deter	mined 200. Fld	ice of Injury - A ilding, etc. (Sp	kt home, farm, s ecify)	treet, factor	y, office		City or Town	n, State)	iber or hura	II Hobie Namber,
נ	To the Hospitel or Attending Phwithin 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral		29a. Certifier 1 Certify	ing Physicien: To	the best of my	knowledge dea	th occurred	at the time	date and place	, and due to the ca	ause(s) and n	nanner as s	tated.
	24 h	edical		I Examiner: On the									
	To the within 2 To the complet	Me	29b. Signature and title of certif	ier //			29	c. License nu	umber	2	9d. Date sign	ed (Month,	Day, Year)
			1 Cuit	- Har	n h	10		053	3306		5/3	110	6
			30. Name and address of perso	n who completed ca	ause of death (Item 23a) (Type	, Print)	,	A 1	1.1	M	1	6 2140 5 MD
			Curps/to	MIS MI	90	00 Bt	25/9	ete 1	Rel	>1 ~ 300	etun	apole;	5 40
		ate	31. Date filed (Month, Day, Yea	1 2006	egistrar's Si	ignature	Carle .						
71	Regist	ıaı .	JÓN 0	T 5000		Nr A		77.h					

		1	For State Registrar	State of Ma	ryland		rtment of H tificate of L		Mental Hy	giene Reg. No	en Christ	9109)
	Physicia		1. Decedent's Name (First, Middle, Last, Eileen Elizabet						2. Date of De Month June		^{1y} 2006	3. Time of Death 5:55 P M	4
	/Medic	al -	4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De			c. County of De		
	Examin	er	Brinton Woods N	ursing & F			Winfi				Carro		
	Funeral Director		5. Social Security Number 6. Sec. 116-3540	7. Age	(In yrs. las:	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		rth ay, Yaar	323 ^{9. 8}	irthplace <i>(State or Foreigr</i> Cou <i>ntry)</i> Maryland	n
	0		Usual Residence of Decedent		10c. City, 1	Four or Lo	antion	1				10d. Inside City Limits	_
	f show	or	MD 10b. County Carr	1			inster					1 ☐ Yes 2 🔯 No	
÷	d within 72 hours after death with the Maryland jiene. Than "naturel", or Items 23a or 28a-f show the Madical Examinet institue modified at	Director	10e. Street and Number 225 Frock Drive	Apt.	323		10f. Zip Code	1157		-	itizen of What of Jnited		
-	dealn	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - An Black, Wi	nerican Indian, nite, etc.	
9	within 72 hours after ene. than "naturel", or Ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	0		☐Yes 2☐XNo	Specify:			Specify:	White	
2-003e	nature nature		15. Decedent's Edu (Specify only highest grad	cation		(Give	ent's Usual Occup	during most of v	vorking	16b. F	Kind of Busines	ss/Industry	
	within and the man	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5-	-)	life. L	Sales C			Mc	ntoome	ry Ward	
מ מ	othe ent,	Be Co	17. Father's Name (First, Middle, Last)				bares		lame (First, Middle			Ly Wald	
Maryland 21	و ق ت ت	ToE	John Myers	D () ()		405 Marila	- Add (Chron		se Ruth K Rural Route Numb			Zin Code)	_
	2 E 2 2		19a. Informant's Name/Relationship (T) Kurt H. Dahlke, J									, MD 21784	
ore,			20a. Method of Disposition 1 Derial 2 XCremation 3 Di	Removal from State	сеп	ce of Dispo	sition (Name of natory or other place	ce)	Date	20c. l	ocation - City	or Town, State	
	Pa ant:	1	4 ☐ Denation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)		Sout			-	June 6,				
Ba	permit. Departm Importe any inju		Musik (11111		B	ırrier-Qu L212 W. C	een Fur ld Libe	neral Hom erty Road	e & Wi	Cremate	ory, PA MD 21784	
			234. Part 1. Enter the disease, or composhook, or heart failure. List only of	lications that caused ne cause on each lin	the death.		er the mode of dyir	ng, such as card	fiac or respiratory	arrest,		Approximate Interval Between Onset and Death	
	nysician /Medical		Immediate Cause (Final iseas for condition esulting in death)	a Non	Suu	nce of):	Cell Ca	remand	of Lu	y		lyear	
	Examiner		Sequentially list conditions	b					15	V.			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i considua	noa of):							
oʻ	execui an and rial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):							
8760,	icate be executed physician and s the burial-transit	dicai		d			···						
Вох 6	leath certifica attending ph I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	cy	Testonia prognana				23d. Date of	•	
Ö.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month	Day Year	
, P.O.	s that the ned by a detact	by Ph	Part II. Other significant conditions co	ontributing to death bu	it not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco		to the cause of death?	
ords	w requires been signe should be	ted b							_ 1 🗆	Yes :		Probably 4 Honknown	
Vital Records,	The law rate has be bage 2 sh	Completed							24a. Wa auto per 1 ☐ Yes	opsy formed?	prior 1 death		9
ital	iclen: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?						Death (Check only				
of <	Physician: this certific ral director,	P	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatier	IL 3 DOA		g Home 5 Res			pecify)	
	Attending Production of the funeral by the funeral	ation	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	(Year)	Injury	Wo	rk? Yes 2∐No					
Division	or Attency after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ary - At hom c. (Specify)	ne, farm, st	reet, factory, office		28f. Location City or To			Rural Route Number,	
	Hospital 4 hours Funeral ely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of hiner: On the basis of and manner sta	examination	ledge, deat on and/or in	h occurred at the ti vestigation, in my o	me, date and pl opinion, death o	ace, and due to the occurred at the time	e cause(e, date a	s) and manner nd place, and c	as stated. fue to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	grid manifol sto			29c. Licens			29d. D	ate signed (Mo	onth, Day, Year)	
)	IN		Vateli T				02	0806		6,	15/06		
	My		30. Name and address of person who	13,UD	Suite	102	Print) /002	0806 O Libor	74 RD	Ele	leishing	an 21784	
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 05	32. Registra			book				/	/	

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health, and Mental Hygiene Jeane Gwenne Daughtery Registrar Amend#'s18.20b.c.PerFHPC06-5-Gertificate of Death 2 Date of Death Month 0428 hrs **Medical Examiner** June 1, 2006 Gwenne Daugherty 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) Funeral Months Days Hours Director Acestralia Jan. 8, 1922 84 577-38-5146 M 2 XX Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 XXNo Oxon Hill Prince George's Marvland hours after death with the Maryland Director 5 23a or 28a-f notified at or Og Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20745 307 Cedar Ridge Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 4. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 2XX No Yes White Specify 4 Divorced If Yes, Give Year 1 Yes 2xx No specify þ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 is marked other than rages I and 2 should be filed within trinent of Health and Mental Hygiene tant: If item 27 is marked or prother trains. timore, MD 21215-0036 8th Homemaker In Home 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Lindsay Jean Lindsay Be Thomas C. Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 14828 Keeneland Circle North Potomac, Maryland Russell Daugherty / Son City or Town, State Virginia 20b. Place of Disposition (Name of cemetery, 6-4-2006 -6/04/06 20a. Method of Disposition crematory or other place) 2 X Cremation 3 Removal from State Arlington, Virginia Arlington Nat. Cemetery permit Pages
Department of
Important: 1 Denation 5 Other Specify 22. Name and Address of Facility (Porge P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or Physician Between Onset and failure. List only one cause /Medical Death a Subdural hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transit Physician/Medical UNPENDED AMENDED item#28e-f,perME,g859,9/1/2006 TT Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. ò 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Division of Vital Be Other4 Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes 28b Time of Injury 28a. Date of Injury 28c. Injury at Work 28d Describe how injury occurred 27. Manner of Death Certification: Subject fell May 31, 2006 0000 hrs Natural 1 Yes 2 V No 5 Pending - death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) H. brew H. m. 121 Month S 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be within 24 hours a. To the Funeral L determined (Specify) Hospital-Nursing Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number June 3, 2006 O.C.M.E. 30. Name and address of person who completed cluse of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 5 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A M 27 5 2006 2:20 Barbara A. DeZarn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Berlin Nursing & Rehab. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. 11/9/1954 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🔼 F MD 51 Director 577-70-2621 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r then "naturel", or iteme 23a or 28e-f shov tre Medical Examinar must be notified at 1X Yes 2 No Directo Pocomoke MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21851 USA 412 Market St., Apt. 1 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker of Health and Mental Hygie If item 27 Ie marked other in other treumstic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 end 2 should be Daisey L. Hadder Alton Foskey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4901 Scotty Rd., Snow Hill, MD 21863 Jeannie Quillen timore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages cemetery, crematory or other place) ō = 5 1 Burial 2 Cremation 3 Removal from State ortant: ! Bowen Cemetery 5/30/2006 Newark, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Furdal Service Licensee permit.
Depertm
Importa
eny inju 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 mos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Months Metastatic Carcinoma of the Bladder /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rectificate has birector, page 2 s autopsy rmed? 2∰No 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certific tuneral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after thin 24 hours aft the Funerel Di mptetely filled in 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifie D28769 May 27, 2006 > 1209 Coosfel they Found Fol De 19244 Bondulia

Registrar
DHMH 17 Rev 1/2001

State

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Registrar's Signature

			1 - For State Registrar		aryland / Dep Ce	ertificate of			Reg. No.	5 19112
	Physici /Medio		Decedent's Name (First, Middle, L John Loos		ıs			2. Date of D Month June	Day Yes	3. Time of Death 12:30 pmu
	Examin		4a. Facility Name (If not institution, gi 148 Cumberla				Spring	ſ	4c. County of D Washir	
	Funeral Director		217-10-3425	Sex 7. Ag ▼□M 2□F	90 Yrs.	Months Days	If Under 24 Hr Hours Mir	8. Date of Bi Month, D	2.9°,1916	Birthplace (State or Foreign Couping)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Washi	ngton	10c. City, Town or Clear	ocation Spring				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 148 Cumberla	nd St.		10f. Zip Code 2 1 7	722		10g. Citizen of What	
920	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show evant, its Medical Exertil artified to its interest to a colline at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyres 2 Telegraphic Hyes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ 🎉	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Race - A Black, W Specify: V	
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	lith ar 27 is r trau		19a. Informant's Name/Relationship Grace Downs	(Type, Print) Wife	P.C	.BOX 44	Clear	Spring	per, City or Town, State , MD 21722	
altimore,	m O		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Dother (Spec		St. Paul	position (Name of ematery or other place CEMETEL	Ju 20	ne 7, 06	20c. Location - City Clear Sp	
Balt	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lice	Luny		22. Name and Addres Donald E P.O.BOX	Edwin T	hompson	n Funeral	Home, Inc
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	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause Julsease of Injury	b	a consequence of):		2			
8760,	cate be executed obysician and the burial-transit	ai Examiner	cause, Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
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.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of 6 Month	delivery Day Year
ecords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause give	en in Part I.		_	to the cause of death? Probably 4 Unknown
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Vital	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:		ont 3C DOA Othe		ath (Check only		
of		lon; To	1 Yes 2 No 27. Manny of Death 1 Natural 5 Pending	28a. Date of Inju	ent 2 ☐ ER/Outpati Iry 28b. Time y Year) Injury	of 28c. Injury Work	/ at	Home Res 28d. Describe	idence 6 Other (S) how injury occurred	pecify)
Division	or Attendition of Att	Certification;	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of Inj	ury - At home, farm, s c. (Specify)		Yes 2 □ No	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best aminer: On the basis o and manner st	f examination and/or i	th occurred at the tin	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
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		4a. Facility Name (if not institution 8981 Wetbanks Cour		number)		4	c. City, To Columi		ocation of	Death			4c. County of Howard	Death	
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death with the Maryland or items 23a or 28a-f sho must be notified at once,	Funeral			d Forces?			s, specify						White	, etc.	
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5-0036 iled within 7: Hygiene. I other than the Medical	탕	17. Father's Name (First, Middle	, Last)						3.Mother's	Name (I	First, Middl	e, Maid	len Surname)		
21215 vuld be file Mental H marked ic event, fi	a	Shashikant Des									na Pa				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relation Swati Allen/S:											, City or Town		(ode)
ore, MD ss I and 2 sho of Health and If item 27 is her traumati	ŀ	20a. Method of Disposition	ESCEL		20b. Place	e of Disposi	tion (Name				Date		c. Location -		State
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Box 68760, e death certificate by the attending physic ed for use as the bu	Physicia	1 Yes 2 No 9 🗸 U	known i = d	eath Inknown		5 Oti	ner (Spec	y)							
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Division of Vital Records, P.O. tal or steeding Physician: The law requires that it is after death. 14 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach											24a. W				findings available
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Division of Vital Rec of the Hospital or Attending Physician: The I within 24 hours after death. To the Finneral Director: After this certificate I completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Check only 2 Medical Ex	Physician: To the aminer: On the ba	e best of my k asis of exami	nowledge, nation and/o	death occur or investigat	red at the ion, in my	time, da opinion,	te and pla death oc	ice, and o curred at	due to the o	cause(s late and) and manner d place, and d	as started. ue to the cau	se(s)
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m(5)		30. Name and address of person													
			Assistant Med			11 Penr	Street,	Baltim	nore, M	D 2120)1				
	ate rar	31. Date filed (Month, Day Year	3 2006	2. Registrar's		e de	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 30 2006 May 11:55A Betty Lee Dobson 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Mallard Bay Nursing & Rehab Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26,1924 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 X F Yrs. 82 Maryland 218-16-8121 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 1X Yes 2 □ No Maryland Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 106 Choptank Terrace USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Government Clerk 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Erol Goldsboro Pritchett, Sr. Sallie Beckwith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Choptank Terrace, Cambridge, MD 21613 Norval Pritchett/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cambridge, Maryland Dorchester Mem. Park 16/2/2006 21. Sign, ture of Funeral Service Dicensee 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eukemiz Due to (or as a consequence of) Sequentially list conditions, Due to (or as a cons » uence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 20 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2500 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 rsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes SQ#10 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

CAMARIDGE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification:

Medical

3 Suicide

29a, Certifier

4 Thomicide

(Check only one)

29b. Signature and title of certifier

Physician

/Medical

Examiner

Director

Funerai

þ

Completed

Be

Funeral

Director

worle

item 27 ie marked other then "natural", or Items 23e or 28e-f ehov other traumatic event, the Medical Examinar must be notified #1

e filed within al Hygiene.

permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event, once.

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

death certificate be executed the burial-transit and attending physician as esn certificate has this

P.O. Box 68760 Division of Vital Records, of or Attending Patter death.

Director: After 1 To the Hospitel of within 24 hours at To the Funerel D

> State Registrar

31. Date filed (Month, Day 1997)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 00 THANUY STREET 2006². Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AU RORA

			For State	State of Maryland	d / Depa		ealth and M	lental Hygi	2000	19115
			Registrar 1. Decedent's Name (First, Middle, Last)	001	tinicate of D	Calli	2. Date of Death	g. No.	3. Time of Death
	Physicia		Charles E.					May 31	, ^{Day} 006 Year	7:00 A M
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or L	ocation of Death		4c. County of Deal	h
	LXamin		Carroll Hospital	Center		Westminst	ter		Carroll	
H	Funeral Director		239 88 9191	x 7. Age (In yrs. I. 55	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 18	Year) 9. Bin Year) Was	hplace (State or Foreign hinty) hington, D.C
1	D	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	sho	ō	MD Carroll	F.	inksbu	rg				1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show fraust be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
7	3a or	0	2112 Sandymount F	Rd.		21048		Ţ	J.S.A.	
	ms 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
۰	or Ite		1 Never Married 🌋 Married	1 ☐ Yes 2 No		**	Specify:			hite
2-0036	within /2 hours after ene. then "natural", or Ite	d by	3 Widowed 4 Divorced	Year or Dates:	160 Dage	dentia Haval Ossusat	ion	1	6b. Kind of Business	(Inductor)
2	"nat	lete	15. Decedent's Edu (Specify only highest grad	de completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	iring most of work	ing	do. Kind of Business	madstry
7	withing the second seco	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Elec	trical Est	timator	I	Arko Elect	ric
Maryland	Id be filed within 72 hours after death with the Marylan death Hygiene. Read other then "natural", or Items 23a or 28a-f show ked other then "natural", or Items 23a or 28a-f show it event, the Madical Evariance could be notified at	To Be C	17. Father's Name (First Middle, Last)			1	Madié A	istin	aiden Sumame)	
ary	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailie	ng Address (Street ar	nd Number or Run	al Route Number,	City or Town, State,	Zip Code)
11.	and 2 alth 8 127 to 187 tra		Mary Early/ Wife		2112	Sandymour				
Baltimore,	ages 1 and nt of Healt : If item 2 or other		20a. Method of Disposition 1 Burial 2 Termation 3 DI		lace of Dispo emetery, crea	osition (Name of matory or other place,	6/0	1/2006 ²	0c. Location - City or	Town, State
Ĕ	Pages ment of ant: If it ury or o		*4 □ Donation 5 □ Other (Specify,	Ca	rroll	Cremations	Inc.	I	Hampstead,	MD
Salt	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service Libers	5,000						Westminster,
	20 = 4 a	_	1900	liesting that agued the death		ritts Fune				MD 21157 Approximate
F	hysician		232 Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	. Hyperter	-sion	ter the mode of dying,	Such as cardiac		ot,	Interval Between Onset and Death
15.	/Medical Examiner		Tooling in doubly	Due to for as a consequence Dinbetes		· L .				
1		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ		(1102				
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0						
oʻ	re be executed ysicien and e burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	uence of):					
1,60	± 2 0	Icai	(d						
9	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:							
Вох	leath certific attending pl	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of do	eath 5L	Other (specify)				
<u>.</u>	w requires that the de been signed by the a should be detached	Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giver	7 in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	sign d be	d by						1 ☐ Yes	s 2 No 3 P	robably 4 dunknown
Ö	w red beer shou	Completed						24a. Was an	24b. Were a	utopsy findings available
Re	he law e has age 2 a	Junc						autopsy	ed? death?	completion of cause of
		Be C	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 th (Check only one		2010
Division of Vital Records,	Physician: The la rthis certificate has ral director, page 2	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Other	,		nce 6 Other (Spe	cify)
0	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at ?	28d. Describe how	w injury occurred	
Ö	endir sath. or: Af he fu	atlc	2 Accident investigation			M 1 2	es 2 No			
<u>≅</u>	for Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st v)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,			ysician: To the best of my kno						
	he Hu in 24 he Fu pletek	edical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	uon and/or ir					
Y		Σ	29b. Signature and title of certifier	1 0		29c. License	number	29 N	d. Date signed (Mont	h, Day, Year)
,	WIL		1 hANN	w)		1062	186		19y S1,	200 b
	13		30. Name and address of person who d	completed cause of death (Item			a	C+0 (1	11 11/011.	21157
			31. Date filed (Month, Day, Year)	32. Registrar's Signa		WMC D	TIVE,	SUCI	J WYCSTV	ninster, Mi)
	Sta Regist		JUN 0 5		H	1 "				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MAY 26, 2006 11:25AM ANNIE JANF EASTERLING /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** MONTGOMERY SLIGO CREEK NURSING AND REHAB TAKOMA PARK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 935 Birthplace (State or Foreign 5. Social Security Number **Funeral** 1□ M 2¥X NORTH CAROLINA 240 48 6259 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show rithan "natural", or Itams 23a or 28a-f shoving Medical Examinar must be notified at XXYes 2 □ No PRINCE GEORGES HYATTSVILLE Directo MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2100 WOODBERRY STREET 20782 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK Specify: ð XXWidowed 4 Divorced Completed be filed within 72 haral Hygiene. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HUDD PAYROLL CLERK 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 is marked of Be ANNIE ADAMS JAMES BRUNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HYATTSVILLE, MD 20782 2100 WOODBERRY ST. BELINDA MARTIN / DAUGHTER or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 06/02/2006 BRENTWOOD, MD 21. Signature of Funeral Service Licensee MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death Part 1 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROTIC HEART DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE. use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ò in the past 12 months? Month 5 Other (specify) 4 ☐ Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CEREBROVASCULAR ACCIDENT, DIABETES MELLITUS, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXInknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION, ANEMIA 24a. Was an page 2 s certificate has autopsy perfor 1 Yes XX No 1 Yes 2 🗀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4XX lursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 1 🗌 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After t XXNatural Hospital or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified June 2, 2006 D46998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HVATTSVELLE, MIS STEVEN TEE, MD 3415 HAMELTON ST.

31. Date filed (Month, Day, Year)



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Gloria Elizabeth Edmonds May 29 2006 9:08 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Community Hospital Chever 1y
If Under 1 Year | If Under 24 Hrs. | Prince George's 8. Date of Birth (Month, Day, Ye. Dec. 31, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1923 Days Hours 1□M 2□F 82 Director 577-28-1009 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f ehow The Medical Examinar must be politied at 1√ Yes 2 No Maryland | Prince George's Glenarden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 8506 Fulton Avenue United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ₩ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be n and Mental I Arthur Holmes Victoria Stateman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If Item 27 le Lana E. Craven / Daughter 405 Winslow RD Oxon Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National June 23,2006 Arlington, VA 21. Signatura of Funeral Service Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike / Forestville, MD Part a tritler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Coronar **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medicai ţ, attending pl IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy performe 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes 2 No To the Hospitel or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 ho To the Fune completely fi

Box 68760,

Records, P.O.

Division of Vital

31. Date filed (Month, Day, Year) State Registrar JUN 0 6 2006

29b. Signature and title of certifier

Daniel Alexander, M.D. 3001 Hospital Dr. Cheverly, Md. . Registrar's Signature

and manner stated

lyande

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D52815

29d. Date signed (Month, Day, Year)

1/060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Amend#18 Per FH g857 7/10/06 Timicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 **Physician** Elsie Month Year fornah 5 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore , MD umms 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State of Foreign 1 M 2 F 43 219613439 Director Vrs MAY 10, 1963 SIERRA LEONE Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County al Hygiene.
I Other than "naturel", or items 23s or zeeveent, the Medical Exeminer must be notified at 10d. Inside City Limits Director MD PRINCE GEORGE HYATTSVILLE 1 XYes 2 No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "naturel", or items 23a or 2 with Injury or other traumatic event, the Medical Examination once. 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3219 TOLEDO PLACE #103 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 HASSAN KOROMA ADAMA ISBLA Gbla 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONATHAN FORNAH/HUSBAND 3219 TOLEDO PLACE #103 HYATTSVILLE, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGE WASHINGTON 06-17-2006 ADELPHI, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Decth **Physician** /Medical Due to (or as a consequence of): Examiner Hepatic Sequentiafly list conditions, if any, leading to initious cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) The law requires that the death certificate be executed burial-transit Hepatitis STATUS POST LIVER TYPNSPLANT physician and Due to (or as a consequence of) Box 68760. Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 Ø No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a peu O 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INTRA - ABDOMNAL SEPSES should I 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 1 Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.9 5/29/06 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Beltimure, MD 21201 ALSON MERCURIUS 22 S green

Registrar

DHMH 17 Rev 1/2001

State

JUN 0 5 2006

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg No.

2 0 5 9 9

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Month Day Year
Month Day May 29, 2006

3. Time of Death
Month Day Year
Month Day Year
Month Day May 29, 2006

Ip Code 817 Jent of Hispanic Origin? (cify Cuban, Mexican, Pue 2 X No specify: al Occupation (Give kind orking life, DO NOT use in 18. Mother's Na Mary ss (Street and Number of rbury Road, ame of cemetery, se)	O1/30/1 10g. U (Specify Yes or Noverto Rican, etc.) d of work done e retired) Aame (First, Middle, Main Lee r or Rural Route Number of Rural Ru	Citizen of What Country? J.S.A. 14. Race - American Indiar White, etc. White Specify: 6b Kind of Business/Industry TCC iden Surname) er, City or Town, State, Zip Code MD, 20817 20c. Location - City or Town, State Prentwood, MD
this Days Hours M app Code 817 dent of Hispanic Origin? (cify Cuban, Mexican, Pue 2 X No specify: al Occupation (Give kind orking life, DO NOT use or orking life, DO NOT use or section of the sect	O1/30/1 10g. U (Specify Yes or Noverto Rican, etc.) d of work done e retired) Aame (First, Middle, Main Lee r or Rural Route Number of Rural Ru	Foreign Country) Ma 10d Insin 1 X You Citizen of What Country? J.S.A. 14. Race - American Indiar White, etc White Specify: 6b Kind of Business/Industry TCC iden Surname) er, City or Town, State, Zip Code MD, 20817 20c. Location - City or Town, State Prentwood, MD asburg RD, Brent, shock, or heart Approx
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		Betwe
		W.
		23d Date of delivery
th 3 Ectopic pre	egnancy	Month Day
pecify)		
ing cause given in Part I.	. 23e. Did toba	acco use contribute to the cause
		2 No 3 Probably 4
	24a. Was an autopsy	
	perform	ned? death?
26 Place of Death (Che	1 Yes 2 heck only one)	No 1 ✓ Yes
.045.		esidence 6 🗸 Other: Scene
28c. Injury at Work?	28d Describe how	
1 Yes 2 V No	Subject fell from	om second floor
		reet and Number or Rural Route
ory, office building, etc.	or Town, Star 5844 Marbury	y Road, Bethesda, MD
ory, office building, etc.	and due to the source/	(s) and manner as started.
the time, date and place,	, and due to the cause(
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tı	the time data and place	t the time, date and place, and due to the cause

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 11 per inf 2856 6-28-06 vt State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death May 27, 2006 01:17 A.M Desmond Paul Ferguson 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton, Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1**X**M 2□F Yrs. May 7, Trinidad, W. India 578-64-5015 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince Georges Upper Marlboro, Maryland 10g. Citizen of What Country? 10e. Street and Number United States 4611 Melwood Road, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify: 3 ☐ Widowed • ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 Supervisor Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Simonese Webb Cecil Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Ferguson / Daughter 934 N. Columbus Street, Alexandria, VA 22314 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 6/2/2006 Clinton, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signal of Funeral Service License e arry commence 5538 Marlboro Pike, Forestville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) aronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown M

Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760, sicien Medical Certification; To Be Completed by Physician/Medical use as the β attending I page 2 should be detached å. peeu hes this certificete in 24 hours after death.

The Funeral Director: After this certific poletely filled in by the funeral director. vithin 24 hours a

Physician /Medical

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

Funeral

Director

Tarrii. Other significant conditions co	milibuling to death but not resulting in the unde	nying cause given in Part i.	1 Yes 2	No 3 Probably 4 Unknow
			24a. Was an autopsy performed?	24b. Were autopsy lindings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	Honoitali		ath (Check only one)	
1·☑Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient	3□ DOA Other: 4□ Nursing H	lome 5 ☐ Residence 6	☐Other (Specify)
27. Mannerol Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury	occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, larm, street, building, etc. (Specify)	factory, office	28l. Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	rsician: To the best of my knowledge, death oc iner: On the basis of examination and/or invest and marner stated.	curred at the time, date and place igation, in my opinion, death occu	e, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier	De	29c. License number D0041580	29d. Date 5 - 3	s signed (Month, Day, Year)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clinton, Maryland 20735 Dr. Scott Kelso, 7503 Surratts Road

31. Date filed (Month, Day, Year)

JUN 0 6 2006



Registrar

	d 20a		•	State of Maryla				•	-	
		•	For State Registrar	orato or many tan		rtificate of			2006	19121
37			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medic		Nikki Ann De	llolio Fen	no			June 1,	2006	1:50 P ^M
	Examin		4a. Facility Name (If not institution, give str 455 Seagull Beach				Frederic		4c. County of Deat Calver	
	Funeral Director		022-40-3136	7. Age (In yrs 48	. /ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 23,	9. Birtl 1957 Ma	nplace (State or Foreign untry) SS•
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD Calvert	P:	rince F	rederick				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	a 23a		455 Seagull Beach	Road . Was Decedent Ever in I	12.1	206		and Was as No	USA	dan tadina
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If ear 27 is marked other than "neturel", or itema 23s or 28s-f show other traumatic svent, the Medical Exp. Irea must be notified at	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		was Decedent of r If Yes, specify Cub 1 ☐ Yes 2 🎛 No	dispanic Origin? (Sp an, Mexican, Puerto Specific	Rican, etc.)	14. Race - Ame Black, White	e, etc.
8	hours tural',	sd by	3X Widowed 4 □ Divorced	Year or Dates:						nite
5	in 72 n "nal	plete	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ang 16	3b. Kind of Business/I	ndustry
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and	be filed stal Hygie of other svent, I	Be	17. Father's Name (First, Middle, Last)		D 11	- •		e (First, Middle, Ma	,	
Baltimore, Maryland	should be ind Mental s marked o umatic sve	၉	Nicola J 19a. Informant's Name/Relationship (Type		Dello		Marilyn		Hegarty City or Town, State, Z	
Z Z	and 2 sho lealth and m 27 is m		Marilyn Ayre (sist			y Point		shfield,		,p dodo,
ore,	of He of He fitem r othe	1	20a. Method of Disposition ↓ ₩ Burial 2 ★ Cremation 3 ★ Per		Place of Dispo	sition (Name of matory or other pla	cal	Date 3	Oc. Location - City or UXDury,	Town, State
Ĕ	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	- C	ouch C e	metery	June 2006	' L	brehfield	MA 02050
Bai	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	2	21. Signatur of Fineral Service Licensee	7	8	125 South	dern Mary	e Funeral land Blvd	Home Calv	vert, PA , MD 20736
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea	th. Do not ent	er the mode of dyll	ng, such as cardiac	or respiratory arres		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	1100	/ Cil	hosis				Onset and Death
	/Medical Examiner		1	Due to (or as a conse	quence of):					Sugars
1.	3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Dus to (ur as a sonse	quanea oll):					- gears
	ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Pan	cent	H				
760,	ate be executed hysicien and he burial-transit	cal E	Tooland of County East	Due to (or as a conse	quence of):					
89	ificate g phys as the		d							
Вох	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	aldeath 3	Ectopic pregnancy Other (specify)	′		23d. Date of delin Month	very Day Year
s, P.O.	res that the digned by the be detached	by Ph	Part II. Dther significent conditions contri	buting to death but not re	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sign should b	eted	(na natrition					1 Tes	2□No 3□Pro	bably 4 Hinknown
Division of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
Vita	ician: cartific actor,	Be	25. Was case referred to medical examiner?	spital:		100		h (Check only one)		
o	Phys r this ral dir	. To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of		4 Inuising no	ome 5 Residen	ce 6 Other (Spec	ify)
on	nding ath. r: Afte e fune	atlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 20001100 11011	injury occurred	
Divis	after des Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special Control of the Control of t	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my kn . On the basis of examin and manner stated.	owiedge, death allon and/or inv	n occurred at the tirvestigation, in my c	me, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
1	To th within To th comp	Me	29b. Signature and title of certifier	n		29c. Licens	1/0/10	,	I. Date signed (Month	Day, Year)
,		1	30. Name and address of person who com	oleted cause of death (Ite	m 23a) (Type	Priot)	001 17		10/06	
	10		Many Mathur	MD	110	40spitul	Rd. B.	rince Fr	ederick n	10 20678
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month May 27, 2006 7:26 a M Charline Elizabeth Franks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 85 Director 579-12-2976 Sept. 25,1920 Mississippi Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits r than "natural", or Items 23a or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Enfield Chase Court Apt. 307 20716 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give ॲ Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 executive secretary U.S. Postal Service and Mental Hygie Injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked othe any lujury or other traumatic event potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Potts Neal Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12041 Palisades Drive, Dunkirk, MD 20754 Gerald E. Franks, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Tother (Specifylentombment So. Memorial Gardens 06-01-06 Dunkirk, MD 27: Signature of Funeral Service, Licensee 22. Name and Address of Facility Mark Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Pheumohia Immediate Cause (Final Physician weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit the ettending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate hes been signed by the epage 2 should be deteched it 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Panerealitis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: ours after death.
Inel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 KNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 46052 5/27/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and Parkway annapolis, MD 31. Date filed (Month, Day, Year) 32. Registra Signature State Bloom It Sparke 2006 Registrar

Amended Item 5 per F.D. 06/05/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year **Physician** HERBERT KENNETH GOSNELL 6:42 P MAY 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Yea Aug • 24, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. S215-26-18054 6. Sex 9. Birthplace (State or Foreign **Funeral** Year) 12 M 2□ F 75 1930 213-36-2949 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinational Burnelliag at once. 10d. Inside City Limits 1 Yes 2XXNo Howard Maryland Mt. Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1674 Florence Road 21771 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Eyre's Bus Service Charter Motor Coach Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alton E. Gosnell Ruth B. Baker ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Frances Gosnell wife 1674 Florence Road Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State South Carroll Crematory June 2, 20006 Winfield, MD 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signature of Funeral Service Licensee Part 1. emer the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mediate Cause (Final Physician sease or condition sulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine with laped lent Reyns days attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at lime of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **N**O 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 ☐ No 2 **X**No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြို Inpatient 2 ER/Outpatient 3 DOA ieral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Fune completely f (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number MIL 15 of perspn who completed cause of death (Item 23a) (Type, Print) Allen 6 31 Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAT 2006 **Physician** 1047 р м GARCIA J. ADAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 11 XM 2□ F 20 1985 El Paso. 629-34-3715 July Texas Diréctor Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-1 show e 23a or 28a-f shov 1XYes 2 No Director Dallas Texas Irving 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 75063 9506 Valley Lake Ln USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ N If Yes, Givel 1 Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1X Yes 2□ No Specify Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Soldier US Army other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cynthia L. Garcia Joe E. Garcia ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joe E. Garcia/Father 9506 Valley Lake Ln Irving, TX 75063 item 27 20b. Place of Disposition (Name of competery, crematory or other plants—Ft. Worth National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 6/2/06 Dallas, Texas 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Murphy FH 4510 Wilson Blvd. Arl., VA 22203 fights that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Eausy on each line. Approximate Interval Between Onsel and Death 23a/ Part 1. Engle the disease, or complication shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) DAYS **Physician** BALLISTIC WOUND OF THE HEAD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant al time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an autopsy performed? 1 X Yes certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 XYes 2 □ No After thi funeral 28a. Date of Injury (Month, Day Year) MAY 22,2005 11:38 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending s after de-ral Director: Alte GUNSHOT WOUND 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* TRAQ Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 X Homicide 0 Baghdad To the Hospital within 24 hours a To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number MAY 28, 2006 ASSOCIATE ME HI-MD-13283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1413 RESEARCH BLVD, ROCKVILLE MD @20850 PHILIP BERRAN MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 0 6 2006

06-03518 Lillie Green

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 19125

		1- For State Registrar		Cer	rtificate	of L	Death		_		Reg. No				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Physici		1. Decedent's Name (First, Midd								2. Date of D Month	Day	Yea		3. Time of De	
dical Exami	ner			een		1				May 24,	2006			1145 hr	s
		4a. Facility Name (if not institution Harbor Hospital	n, give street and n	umber)			. City, Town, or Baltimore	Location of	of Death		4	c. County o	of Death		
Funeral Director		5 Social Security Number 241-44-2367	6. Sex	7. Age (In yrs. Ia	1	Yrs	If Under 1 Year Months Day			8 Date of Feb.	,		9 Birth Foreign Cou	North C	arolin
_		Usual Residence of Decedent				110				1200					
any		10a. State 10b. County		10c. City,	Town or Lo	ocation	ו							10d. Inside (City Limits
ž ,	'n	Maryland Prin	ce George	Mi	tchel	lv:	ille						- 1	1 XXYes	2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene is a marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1312 Forest	Lake Cour	t			10f. Zip Code	20721			_	nited			
with a		11. Mantal Status	12. Was De	cedent Ever in U.	.S. 13.	Was	Decedent of His	panic Orig	ın? (Spe	cify Yes or	No-	14. Race	- Americ	an Indian, Bl	ack,
leath r item	Funeral	1 Never Married 2 M	arried Armed F	orces?		If Yes	, specify Cubar	ı, Mexican	Puerto F	Rican, etc.)		White	e, etc.		
after c	by F	3 Widowed 4 X Div	orced If Yes, Give Ye		1	Y	es 2 X No	specify:				Specify:	Bla	ck	
ours a		15 Decedent's Education (Spe	cify only highest gra	de completed)			Usual Occupa t of working life				16b.	Kind of Bus	siness/In	dustry	
6 n 72 h au "r ical E	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		-	-			,,		Educa	tion	/Dry (Cleaner
5-0036 iled within 7 Hygiene d other than	Juc	12 17. Father's Name (First, Middle,	6		Teach	er,	Busine			First, Middle					
21215-0036 uld be filed within 72 hours after de Mental Hygien marked other than "natural", or e went, the Medical Examiner mi	Be C	Shellie Wr:					- 1			cNeil	e, iviaider	i surname)			
2121 nuld be fi Mental marked c event,	о В	19a. Informant's Name/Relations	_		19b. Ma	ailing A	Address (Stree				umber, (ity or Towr	n. State.	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 men of Health and Mental Hygiene taut: If item 27 is marked other than 'or other traumatic event, the Modical	_	Adrienne J. G	reen/Daug	hter			emberto						606	,,	
ore, Nest I and of Health If item		20a Method of Disposition			Place of Dis crematory o		on (Name of ce	netery,		Date	20c.	Location -	City or T	own, State	
ages nt of nt: If other			n 3 Removal f	omotate			morial	Park	Time	1. 200	6	Lando	ver.	MD.	
Baltimore, permit. Pages I and Department of Heal Important: If iter injury or other tra		4 Donation 5 Other Signature of Funeral Service		1/11/11/11			me and Address			e Fune 8 Mar	- 1			125	
Dep Depri		ava 1	Mikel	X					553 For	8 Mar estvi	lbor lle.	o Pik Md.	e 207	47	
Physician		23a. Part I Enter the disease, or failure. List only one cause		caused the death.	Do not ent	ter the	mode of dying,	such as ca						Approximate Between O	
/Medical Examiner		Immediate Cause (Final disease	Librara de cara	ive Atheroscl	erotic Ca	ardio	vascular Dis	ease						Dea	
-xammer		or condition resulting in death)	Due to (or as	a consequence o	f):										
per l	-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	f):									_	
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ed sit	Examiner	events resulting in death) Last		a consequence of	f):										
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		UNPENDED	dAMENDED												
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8760, rtificate bi ing physic as the bur	an/N	23b. Was decedent pregnant in the past 12 months?				Fetal	death 3	Ectopic	pregnan	су	-	Month	Da	ny '	Year
Box 6 e death cer the attendi	sici	1 Yes 2 No 9 Uni	CONTRACT CONTRACT	nant at time of de	ath 5		r (Specify)								
. BC	Physicia	Part II. Other significant condit	9 OHKII	own o death but not re	oculting in th	ho uno	tortuina couso	iiyon in Do	rt I	23a Dio	Itohacco	use contrib	buto to th	ie cause of d	eath?
tal Records, P.O. Box 68: cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as it		Diabetes Mellitus; Ch			-		enying cause (jiven in Pa	11.1.	1				bly 4 🗸 U	
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of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should	Be (25. Was case referred to medica examiner?	Hospital:	F***		_		of Death			7	_	_		
of Ving Physical After this	1º	1 Yes 2 No 27. Manner of Death		Inpatient 2						Home 5		ence 6	Other:		
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this centifi completely filled in by the funeral director.	Certification;	dete	d not be Specify		ome, ram, s	sireet,	ractory, office t	unding, et	·	or Town		and Numbe	i oi Ruia	n Route Num	iber, City
lospi 4 hou funer		4 Homicide 29a. Certifier 1 Certifying P	hysician: To the be	st of my knowled	ge, death or	ccurre	d at the time. d	ate and pla	ce and d	ue to the ca	use(s) a	nd manner	as starte	d	
To the Hospital within 24 hours To the Funeral completely filled	Medical	TOOK DINY	miner: On the basis and manner:	of examination a	_										
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		•	1 - State Registrar	State of M	faryland / Depa Cer	artment of H			ene 2 0 0 6	19126
	2100		Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
¥ .	Physici /Medic		David Zimmerman	Gardner	Sr.			June	Day Year 5 , 2006	10:35 P ^M
	Examir	_	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Deat	
			3440 Harpers Ferry	Road		Sharpsbu			Washingto	n
A	Funeral		5. Social Security Number 6. Sex	7. A M 2□ F	Age (In yrs. last birthday) Q 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Co	nplace (State or Foreign untry)
F.	Director		220-18-3387		81 Yrs.			May 5, 1	925 Shar	psburg, MD
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Ff sh	to	Maryland Washingto	n	Sharpsbur	• 0				1 ☐ Yes 2 🔀 No
	r 288	Director	10e. Street and Number	11	J Silai psoul	10f. Zip Code		10	g. Citizen of What Co	untry?
	th wit		3440 Harpers Ferry	Road		21782			USA	
	r dea	Funeral	11. Marital Status	Was Deceder Armed Forces	2	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	hours after death with the Maryland turel', or Iteme 23a or 28a-f show al Examinar must be notified at	by Fu	1 Never Married 2 Married	1 Yes 2 [If Yes, Give		1 ☐ Yes 2X No	Specify:			ite
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Maryland 2121	be filed within 72 hours after death with the Marylar lat Hygiene. d other than "natural", or Iteme 23a or 28a-f show event, the Medical Examine must be naitled at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
Jai		To E	John William Gar	dner			Martha	Ann Roh	rer	
a	and and		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a	and Number or Rui	al Route Number,	City or Town, State, Z	ip Code)
	Health tem 27 other tre		Alice M. Gardner	(Wife)			erry Rd.		urg,Maryla	
ore	ges 1 t of H if Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from Stat	20b. Place of Dispo cemetery, crea	isition (Name of natory or other plac	(e)	Date 2	Oc. Location - City or	Town, State
Baltimore,	tmen tant:		4 □Donation 5 □ Other (Specify)			THE RESERVE AND PROPERTY AND PERSONS ASSESSED.	AND DESCRIPTION OF THE PARTY OF	7,2006 S	mithsburg,	Maryland
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£.			23a. Pert. Enter the disease, or compli	cations that caus	ed the death. Do not ent	er the mode of dvin	nsport, M	ary land	21795	Approximate
	5 1		shock, or heart failure. List only on Immediate Cause (Final	e cause on each	line.	,	3.			Interval Between Onset and Death
Ja.	Physician /Medical	. !	disease or condition resulting in death)		s a consequence of):	lure				
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8760,	Hospital or Attending Physician: The law requires that the death certificate be executed at hours after death. Funeral Director: After this certificate has been signed by the attending physicien and telligifiled in by the funeral director, page 2 should be detached for use as the burial-transit	dlcal	d							
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o	the de	yslo	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown		Other (specify)				
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gp.	luires sign	d by						1 🗆 Yes	s 2□No 🎾Pro	bably 4 Unknown
Records,	w requires been si	lete						24a. Was an	24b. Were au	topsy findings available
	The lay	Completed						autopsy perform 1 Yes 2	prior to c	ompletion of cause of
Vital	ysiclen: The is certificate hadirector, page	0	25. Was case referred to medical				26. Place of Dear	1 ☐ Yes 2 h Check only one		2 🗆 No
	Physicl this cer al direc	To B	examiner? Yes 2 No	ospital: 1 🗌 Inpa	tient 2 ER/Outpatier	nt 3 DOA Othe			nce 6 Other (Spec	ufy)
0	Attending Ph or death. ector: Atter th by the funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of In	ijury 28b. Time o Day Year) Injury	28c. Injury Work	at	28d. Describe how	w injury occurred	
<u>0</u>	death. ctor: Afr	atle	2 Accident investigation				Yes 2 □ No			
Division of	fler d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	pltal		29a. Contilior 1 Certifying Phys	Gran W. A. A.						981089
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the the temporal process.	Medical		er: On the basis	st of my knowledge, death of examination and/or in stated.	vestigation, in my of	ne, date and place, pinion, death occur	red at the time, da	use(s) and manner as te and place, and due	to the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier			29c. License	a number	29	ld. Date signed (Month	, Day, Year)
	. , , , ,		> SM no			Aco.	56965		Jim 7	100/
			30. Name and address of person who co	mpleted cause of		Print)	56965			1000
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			For State Registrar	State of M	aryland			nt of H		nd Me		iene	200	16	19	127
	Physici		1. Decedent's Name (First, Middle, Last Estelle Ledbetter							2	Date of Deat Month	<u> </u>	Yø	ar	3. Time of 6:32	
0.5	/Medio Examin	er	4a. Facility Name (If not institution, give Prince Georges I	street and number)				Cheve			- 00	4c. C	ounty of D	eath	eorge	
	, Funeral Director		5. Social Security Number 6. Se 174-34-0418 Usual Residence of Decedent	x 7. Ag ☐ M 2[x] F	62	ast birthday) Yrs.	If Unde Months	r 1 Year Days	Hours I	Hrs. 8 Min.	Date of Birth (Month, Day, 09 08	Year) 43	9.	Birthplac Country P		r Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, I'm Medical Exactional matter required at Once.	To Be Completed by Funeral Director	10a. State 10b. County MD Prince G 10e. Street and Number 11203 Lake Vist 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Ed. (Specify only highest grace) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Matthew Ledbette 19a. informant's Name/Relationship (T) Angela L. Hughes 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens)	a Lane 12. Was Decedent Armed Forces: 1	Ever in U.S. No	16a. Deced (Give life. I Day 19b. Mailir One Journal of Disposimetery, crem. Linco	Nas Dece f Yes, spe of Yes, spe of Yes, spe of Yes, spe of Yes of	al Occupant done done done done done done done done	spanic Origin n, Mexican, F Specify: Ition uring most of ector 18. Mother's Rosa nd Number of errace a) ery 06 s of Facility	Name (ibell br Rural F Dat -07- Stri	First, Middle, I Kerse Route Number per Ma:	Un: 16b. Kind Priv Maiden S y City or r1bo: 20c. Loca Bren Fund	Specify: d of Busing Vate- umame) Town, Stat ro, M. ation-City twooderal	Stat American White, etc Blace ass/Indus Non Te, Zip Co Towr Towr Serv Serv	es In Indian, co. Ck Stry Profit Ode) 0774 7ices,	2□No it
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Scalar thilly list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LIVEY Due to (or as LIVEY Due to (or as	a conseque	L. Do not ent. L. Do not ent.								A	pproximate sterval Betwonset and D	ween
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal	death 3□	Ectopic p Other (s					23	d. Date of Month	delivery Da	ay Y	'ear
9	n requires that been signed b should be deta	eted by	Part II. Other significant conditions co	ntributing to death b	out not resu	ulting in the ui	nderlying	cause give	n in Part I.			s 2 🗆		e to the		eath? Inknown
Vital Records,		е Сошр	25. Was case referred to medical						26 Place of	Death //	24a. Was a autops perform	ned?	24b. Were prior death	to comp	y findings a letion of ca □ No	vailable iuse of
Division of Vi	Physic r this ce ral direc	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	lo spital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	iry y Year)	ER/Outpatien 28b. Time of Injury	М	28c. Injury Work 1 🗆 Y	r: 4 🗀 Nursii	ng Home	5 ☐ Reside	ence 6		Specify)		
Divi	or A		4 Homicide determined	28e. Place of In building, et sician: To the best	of my know	wledge death	OCCUITE.	l at the tim	e, date and n	place and	f. Location (St. City or Town	, State)	nd manna	r ac state		
	the the the	Medical	(Check only 2 Medical Examone) 29b. Signature and the of certifier	ner: On the basis of and manner st	f examinat	ion and/or inv	vestigation	n, in my op c. License	inion, death o	occurred	at the time, da	ate and p	lace, and signed (M	due to th	e cause(s)	
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4	0		30. Name d dress of son who co DR GARY LITTLE	30	01 4	t05P17	Print)	DRI	8951 VE	C.	HEVER	LY,	MD	21	0185	
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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** May 31, Elmer 12:35 P M Harshbarger 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Nov 10, 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 86 Director 176-14-7826 Penna. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Wedical Examinational benefitted at MD St. Mary's 1 Yes 2X No Director Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is markad oth any injury or other traumatic evant 2008. Howard Peter Harshbarger Mamie Bell Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Harshbarger (nephew) 116 Starview Blvd. Mt. Wolfe, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 22 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2006 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 23a. Parl 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner 061 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit 4 Portion that initiated events resulting in death) Last Due to (or as consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy 1☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 1_Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of confifie 29c. License number 29d. Date signed (Month, Day, Year) 02/06 000619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD Manoj Mathur, MD 110 Hospital Road 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar 2 2006

			1 - For State of Marylar Registrar		artmer <i>rtificat</i>			and M	-	giene Rog. No	ZUUD	19129
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Thomas Monroe Hall						2. Date of De Month May 30	ath Da		3. Time of Death 11:45A M
	Examin		4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				Location o				County of Dea	
	Funeral Director		5. Social Security Number 214–28–9174 6. Sex 7. Age (In yrs. 75	last birthday) Yrs.	If Under		If Under 2 Hours	24 Hrs. Min.	8. Date of Bird Month Da Feb 9	h	9. Bi	ithplace (State or Foreign Country) St Virignia
	Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Calvert	ity, Town or Lo Lusby	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N 3a or 28a-	Funeral Director	10e. Street and Number 11380 Mill Bridge Road		10f. Zip	Code 206	557			-	izen of What C	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mcdical Examinat must be notified at ance.	by Funera	11. Marital Status 1 Never Married		Was Decedif Yes, spe	cify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify:Wh	ite, etc.
Maryland 21215-0036	ithin 72 hou ne. nen "natural e Medical E.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done a	turing most	of working	g		ind of Busines	
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ylar	d Menta	To B	Leander Wesley Hall	401 14 11		10:			ixie S			
	and 2 shealth and 27 is n		19a. Informant's Name/Relationship (Type, Print) Victoria Hall — wife						Lusby,	-	or Town, State, 20657	Zip Code)
altimore,	Pages 1 ament of He tant: if itan			Place of Dispo cemetery, crer outhern	matory or o	ther place rial	Garc	dens		Dunk	cation - City o	
Ball	permit Depart import any in		21. Signature of Funecal Service Licensee	44	2. Name ar .05 Br	d Addres	s of Facility	Raus	ch Fund Port 1	eral	. Home	20676
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rds, P.O	w requires that the de been signed by the a should be detached f	by	Part II. Other significent conditions contributing to death but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to			o the cause of death?
Vital Records,		Completed							24a. Was autop	sv	death?	utopsy findings available completion of cause of
VIII.	Attanding Phyaician: The ordeath. ector: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatien	nt 3 🗆 DC	A Cthe	are .		Check on o		6 □Other (Spe	acifu)
o u	ding Phy h. After thi funeral o	ion: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	1 2	8c. Injury Work	at ?	28	3d. Describe h			outy)
Division of	or Attsndi after death. Director: A d in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	M eet, factory		′es 2⊡N	1	3f. Location (S City or Tow			tural Route Number,
	To the Hospitel or At within 24 hours after d To the Funaral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my kni and manner stated.	owledge, death ation and/or in	vestigation	in my op	inion, deat	d place, ar h occurred	nd due to the o	ause(s) late and	and manner a I place, and du	s stated. e to the cause(s)
ı	with Com	2	29b. Signature and title of certifier MO			License	number 3 9 0)		29d. Dat 5 /3	e signed (Moni	th, Day, Year)
_	6		30. Name and advess of person who completed cause of death (Itel ADEER JABER 100 HESPITAL RO	п 23a) (Туре.	Print)	REDE	ERICK	MO	20(78		
	Sta Registr		ADEEB JABER 100 HOSPITAL RO 31. Date filed (Month, Day, Year) 32. Registry's Signar JUN - 1 2006	ature &	Spa	L)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:30 June 4 2006 Ellen Hester Haas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Nursing & Rehab. Center Berlin If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) 12/17/1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF MD Director 213-22-4688 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities must be notified a once. 1 ☐ Yes 24 ☐ No Director Berlin Worcester MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 21811 76 Abbyshire Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Completed by 3 ™ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Lynch 2 Lawrence Hitchens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6817 Chip ewa Dr., Baltimore, MD 21209 Linda Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 6/6/2006 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 234. Part . Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardisvasculer reus **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) NO P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records. 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes certificete Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes this After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Funeral Director: A to the Funeral Director: A death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Centifying Physician: To the best of my knowledge, death occurred at the fine, date and place, and due to the cause(s) and nanner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 1209 Coastal Highwy Fewrick Fol, De 1994 DN2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 5 Registrar

ORIGINAL

				partment of Health and Me ertificate of Death	_	ene 006	9 3				
	(1) 第		Decedent's Name (First, Middle, Last)	1:	2. Date of Death		3. Time of Death				
- 25	Physici /Medi		Roy Dale Harbaugh		June June	4 2006	7:00AM				
V	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea					
		× .	328 Woodpoint Avenue	Hagerstown		Washin	gton County				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	rthplace (State or Foreign				
ũ,	Director		219–60–4419 ¹ ¼ ^M ² □ F 51 Yrs.		July 9 1	~ - 4	aryland				
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	location			10d. Inside City Limits				
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	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow the Madical Examiner must be notified at	Funeral			of Yes or No-	14. Race - Am					
رم.	fler	F	1 Never Married 2 Married 1 ☐ Yes 2 No	B. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, Whi	ite, etc.				
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7/8	should and Men marke umatic	၉	Roy Kenneth Harbaugh	Freda	Blanche	Snyder I	Harbaugh				
Maryland	C1 00 -2 08		ALCOHOLOGO CALLON BY	iling Address (Street and Number or Rural)	Route Number, C	ity or Town, State, .	Zip Code)				
	1 and Health em 27 ther tr		Rachel Ann Harbaugh 20a. Method of Disposition 20b. Place of Disposition	Woodpoint Ave. Hag	erstown	Maryland	21740				
פֿר	in it of l		11√2 Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)							
Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 any njury or other once.	1	4 Donation 5 □ Other (Specify) Manor Ch 21. Signature of Funeral Service Licensee	Brethren Cem June	8 06	Boonsbor	o Maryland				
Ba	Department of the contract of			22. Name and Address of Facility Dov 1331 EasternBlvd. N							
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not expect, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a targequence of):	nter the mode of dying, such as cardiac or failure Aprila-	respiratory arrest		Approximate interval Between Onset and Death Oss Phons				
8760,	icate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	, blessey							
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	uires that signed b id be deta	6	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		_	o the cause of death?				
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Re	he fav e hes ige 2:	E C	() (/2001)001/)		autopsy	pnor to	completion of cause of				
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5	Physician: The I r this certificate he ral director, page	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (se 6 ☐ Other (Spe					
Division of Vital Records,	Attending Phy or death. ector: After thii by the funeral c		27. Manner of Death 1. Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 28	e 3 Head of the How		клу)				
Divis	i or Atten efter deal Director:	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal can be compared to the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)				
	within To the	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	th, Day, Year)				
			1 - Huble	021898		6/5/0 L					
5	H-10		30. Name and address of person who completed cause of death (Item 23a) (Type FKN) CISCO L. ANDRADE 350	D27898 HILLST. HAGER	estowe	HO21	742				
	Sta Registi		31. Date filed (Month, Day, Year) 32. Resistrar's Signature	Poerte							

			1 - For State Registrar	State of M	arylar				ealth ar Death		F	Reg. No.	400	6	91	32
	Physici /Medic	al	1. Decedent's Name (First, Middle, L. BEUCAH	14	t	+ En			Landin of		Date of Dea Month	Day 2	720		3. Time of 183	
1	Examin	er	4a. Facility Name (If not institution, git Anne Arundel 5. Social Security Number 6.	Medical (er	Ann	apo r 1 Year	Location of lis		. Date of Birt	Ar	nne A	rur		r Foreign
	Funeral Director			. D	95	Yrs.	Months		Hours	Min.	Date of Birt (Month, Date eb. 26	Year)	911 E	lor	ace (State of y) ida	- Crongri
	e Marylan 3a-f show	ctor	MD Anne Art	ındel		ty, Town or Loo brills	cation							10	d. Inside Cit	•
	h with th	al Director	10e. Street and Number 1706 Justin Drive	9			10f. Zij)54				_	Citizen of What Country? nited States			
920	be filed within 72 hours after death with the Maryland nat Hygiene. Ind other then "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be mailied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Bfack, White, etc. Specify: White					
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natu	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12	Education rade completed) Coflege (1-4or	5+)	16a. Deced (Give life. L	kind of wo	al Occupa ork done d use retired	furing most o	of working			ind of Busin		ustry	
yland 2	should be filed nd Mental Hygir marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Las Joel Wiley Kelley	7				!	Ella <i>P</i>	Aycoc						
	ad 2 shullth and 27 le m		19a. Informant's Name/Relationship Linda Munday	(Type, Print) Baughter)			•				Rou <i>te Numbe</i> rills,				Code)	
Baltimore,	permit. Pages 1 are Department of Heal Important; If Item eny Injury or other pace.		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec			Place of Dispo cemetery, cren rkhill	natory or	other plac	100	ine 2 006			umbus	-		
Balt	permit. Pages Department of Important; If I eny Injury or one		21. Signature of F negal Syrvice Lic	ensee	M009						t Funer) Annapo					s
100	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resuffing in death)	npilications that cause y one cause on each I a Due to (or as	ne. 57	mok		de of dying	1		espiratory ar	rest,			Approximate Inferval Befo Onset and D	v eeл
1760,	icate be executed physicien and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C												
.O. Box 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medica	fFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Feta	aldeath 3□	Ectopic p Other (s	oregnancy pecify)					23d. Date o Month		,	'ear
rds, P	quires that n signed t	þ	Part If. Other significant conditions	contributing to death t	out not res	sulfing in the u	nderlying	cause give	en in Part f.	_	23e. Did to		.1		e cause of d	
I Records,		Completed	AFIB							_	24a. Was autop perfo 1 Yes		prior to completion of cause of death?		available ause of	
Vital	Physicien: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ant 2	ER/Outpatien	nt 3□ D	OA Othe	0.57		Check only o		6 DOthor	'Snaart	1	
ion of	Jing After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		28c. Injury Work	/ at	286	le 5 Residence 6 Other (Specify) 8d. Describe how injury occurred					
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After cimpletely filled in by the funer	Medical Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be an Place of Leiter Africa for the form of the State of						Street an vn, State	reet and Number or Rural Route Number, n, State)					
	• Hospi 24 hou • Funer letely fill	dicai	29a. Certifier (Crieck only one) Conect only one)	Physician: To the best audiner: On the basis of and manner s	t examin	owledge, death ation and/or in	h occurred vəstigation	d at the tim	ne, date and pinion, death	place, and occurred	d due to the at the time.	cause(s) date and) and manne d place, and	er as sta due to	ited. the cause(s)
	To the within To the Complex c	Me	29b. Signature and title of certifier	r Afe	W.	r un		c. License		143	8		te signed (A	_	_	76
	70, -4		30. Name and address of person of the state	Lolono	M	1 445	Print)	ens e	H161	rtw Ay	8 A~	NAS	out M	10	V1411	
	St Regist	ate rar		2006 32 Regist	ais sign	k L	and i	,								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Naomi Elizabeth Johnson 7:00 P M May 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Elder Care LaPlata, Prince George If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplece (State or Foreign Country) Months Days Hours Min 1□M 2□F Yrs. 579-42-1157 Director 74 May 2, 1932 Gio, N.C. Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Mudical Examinar must be notified at 1∏Yes 2∏No Director Maryland Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed withIn 72 hours efter death with 5017 Red Horse Court 20603 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Twelth Custodian Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fittent of Health and Mental Htant: If Itam 27 Is marked of Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Johnson/Husband 5017 Red Horse Court, Waldorf Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. * 4 ☐ Donation May 30,2006 5 Other (Specify) Maryland Veterans Cheltenham Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Kd SE, Wash DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Pear Immediate Cause (Final **Physician** ANCIEN disease or condition resulting in death) 5 /Medical Due to (or as a consequence Examiner KWO METABLI. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit that initiated events by the ettending physicien end resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KNo 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **X**No 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funerel DI 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signatufe and title of certifier 29d. Date signed (Month, Day) Year) 29c. License numbe

State Registrar

George Wathen 31. Date filed (Month, Day, Year)

11345 Pembrooke Square #103, Waldorf, Maryland 20603 2. Registrar's Signature JUN 0 5 2006

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SENIFER Year **Physician** WUEEN SEGINA 6.55pm 05 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA YARK, MD MONTEOMERO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 25€ 577 32 4490 Director MAR Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ahow event, the Medical Examiner must be notified at DC 1 Yes 2 No WASHINGTON Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? JACKSON STREET N.E. is 1 and 2 should be filed within 72 hours after death with if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or ? U.S.A 20017 1260 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$2700 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 Specify: BIACK 3 Midowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LASHIER OTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SOHNO C) WEEN JOLDRINE Pages 1 and 2 should traumatic 19b. Mailing Address (Street and Number or Flural Poute Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) JENIFERJR DON VIRGINIA MONTPELIER, other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition o = ö Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or MT. DIVET CEMETER 6/3/2006 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonatury of Funeral Ser T RHINES F. H. WASHINGTON, DC 20017 3015 12 TH STREET N.E. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Drumonio /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 3 Probably 4 ☐Unknown 1 Tes 27 page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Impatient 2 ER/Outpatient 3□ DOA the funeral Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Diractor: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 28 D 63439 2006 30. Name and address of person who comprehed cause of death (Item 23a) (Type, Print)
NANDURI KUSUMAKALYANI, 7600, Care & Laberne, Takana Panke Mary land . Registrar's Signature State JUN 0 6 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year Vernell Jones May 29, 2006 9:35a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 🖳 F 81 579-30-6878 Yrs. Director Feb. 22, 1925 | North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County irel', or iteme 23a or 28a-f shor Examiner must be notified at 1 Yes 2 No Funeral Director Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20019 402 59th Street N. E. United States nit. Pages 1 and 2 should be filed within 72 hours after death erment of Health and Mental Hygiene. ortant: If tem 27 le marked other then "naturel", or teme 23 injury or other traumatic event, Its Mental Examine mass 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 2 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Hallie Mitchell Junious Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Cooke / Sister 78 Sutton Rd. Louisburg, N.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haywood Church June 3,2006 Louisburg, N.C. Depertimport eny injustic 22. Name and Address of Facility
Alexander, S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 21. Signature of Funeral Service Lives ee 23a. Part1. Enler the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dire to (or as a consequence of): The faw requires that the death certificate be executed attending physicien and for use es the burial-transit Exam Cerebrovasculiar Stroke resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Dermatomyositis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Vita or Attending Physicien: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Medical Certification: To Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Dire within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stel Tayont M.D. D 00 5258 5/29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel M. D. 1500 Forest Glen Silver Spring, Md. 20910 Jayanti

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2006

32. Registrar's Signate

			For State Registrar		State	of Maryl		artment of Fertificate of		_	giene ,	2006	19138
dig	r.		1. Decedent's Name (F	First, Middle, La	st)		T		****	2. Date of De	ath	Vara	3. Time of Death
н	Physicia /Medic		514	LAS.	JACK	SON	, JR.			Month	28	2006	9:45 pm
y.	Examin		4a. Facility Name (If no					4b. City, Town, o	r Location of Dea	ath	4c. Co	unty of Death	
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	Funeral		5. Social Security Num	_ •	ex M 2□F	7. Age (In	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year)	Count	ace (State or Foreign
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	and w		10a. State 16	0b. County		100	. City, Town or I	ocation				10	d. Inside City Limits
	hours after deeth with the Maryland turel', or Items 23a or 28a-f ehow al Exeminer must be notilled at	ō	Maryland	Prince	George'	s	Capito	1 Heights	3				M∐Yes 2 ☐ No
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	ms 2	Jera	11. Marital Status	приите	12. Was Dec	cedent Ever	in U.S. 13	Was Decedent of H	lispanic Origin? (Specify Yes or No		Race - America	an Indian,
9	after or the	Ē	1 🗋 Never Married	2 Married	Armed F	2 No		If Yes, specify Cuba		no Hican, etc.)		Black, White, e	tc.
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22	iled v Hygie ther t	ပိ	17. Father's Name (Fin	ret Middle Last	1		K	epairman	18 Mother's N	ame (First, Middle		vate	
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2	hould de Me	ဥ	19a. Informant's Name				19h Mai	ling Address (Street				own State Zin	Code)
Ma	d 2 s th an trau		Kathleen V		•	Daucht		Jameson					748
ē,	Heel Heel tem 2		20a. Method of Dispos		Lams /		Ob. Place of Disp	osition (Name of	1	Date		ion - City or Tox	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Importent: if item 27 ie marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.		1 € Burial 2 □ 0 4 □ Donation 5				•	ematory or other place 11 Cemete:	' 1	2006	Suitla	and, MD	
	ertme orter Injur		21. Signature of Fune	11		10		Name and Addre					
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	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cardal or Deshare transport and Death Conset and Death										
1			Immediate Cause (Final disease or condition resulting in death) a. Cardio Respitatory artest Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):										
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<u>α</u>	\$ 8 g		Part II. Other significa	ant conditions	contributing to	death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to the	e cause of death?
Records,	ures rign	d by	Alechein	ners	demen	tia,	NOD			1 🗆	Yes 2 🗆 N	lo 3 🗆 Proba	ably 4 Dunknown
00	w requir been si should	Completed						s, UT	/	24a. Was	an 2	4b. Were auton	sy findings available
Re	The lav	E G	7-2172			1	repsi	S, U1	/	auto perfe	psy ormed?	prior to con death?	pletion of cause of
Vital		Ö	25. Was case referred	d to medical	-				26 Place of D	eath (Check only	2.M(No	1 🗆 Yes	2∐ No
<u>></u>	Physician: r this certific ral director,	0	examiner? 1 ☐ Yes 2 🕱 No		Hospital:	Inpatient	2 ER/Outpatie	ent 3 DOA Oth	0.00	Home 5 Resi		Other (Specify	1
) of	g Ph	T:U	27. Manner of Death		28a. Date	of Injury onth, Day Yea	28b. Time	of 28c. Injur		28d. Describe			
jo	Attending I death. ctor: After y the funer	atio	2 Accident	5 Pending investigatio	n	, Day 700	,,uiy		Yes 2 Ho				
Division	or Attending after death. Director: After in by the fune	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 Could not be determined	280. Plac	ce of Injury - ding, etc. (S)	At home, farm, s	treet, factory, office			Street and N wn, State)	lumber or Rural	Route Number,
	ospital or Attend hours after death uneral Director; /												
	To the Hospital or Attending 24 hours after de To the Funeral Directo completely filled in by the	edicai	(Uneck only 2)	Certifying Pl	miner: On the	basis of exa	y knowledge, dea mination and/or	ath occurred at the tin	me, date and pla ppinion, death oc	ce, and due to the curred at the time.	cause(s) an	d manner as sta ace, and due to	ited. the cause(s)
	thin 2 the 1 the 1	Med	one) 29b. Signature and titl		and ma	nner stated.		29c. Licens				igned (Month, L	
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0	(2)		30 Name and address	e of porcon ut-	rompleted	ISO OF STATE	(Item 22a) (T:=	Print) #	55362		0 5	1 00	
	9		30. Name and address	2/0/	East	fell.	(Item 23a) (Type	L DRIN	TH SEA	MA MA	822	sen fra	promote -
Ψ.	Sta	ite	31. Date filed (Month,	Day, Year)	20	Registrar's S	Signature	1. Defly	rue!	111 20	11		
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State of Maryland / Department of Health and Mental	Hygiene	0

			For Stata Registrar	State of Ma	ryland	•	tificate of		ı Mentai m	ygien Reg. N		10101	
1	Physicia	an	Decedent's Name (First, Middle, Last)	oleo Ion	0.0	-			2. Date of D Month May 3		ay 06	3. Time of Death	
1	/Medic	al	Katharine Brooke Jones 4a. Facility Name (If not institution, give street and number)				4b. City. Town, o	4b. City, Town, or Location of Death			c. County of Death	2:45 PM	
	Examin	ęr	15107 Interlachen I		. 101	2	Silver				rince Geo	rges	
i	Funeral Director		5. Social Security Number 6. Sex 10 10 1		(In yrs. las		If Under 1 Year Months Days		in. Februa				
	land ow	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation				1	Od. Inside City Limits	
	a-f sh	ctor	Maryland Montgomery	7	Silv	er Sp	ring					1X Yes 2 □ No	
	th with the 23s or 28	Funeral Director	1.100								Citizen of What Country? United States		
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23e or 28e-f show event. The Medical Examinat multibe mailified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	☐ Yes 2 X No Yes, Give			as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 ☐ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
5-0	"natur	Completed by	15. Decedent's Educa (Specify only highest grade	tion completed)		16a. Deced	dent's Usual Decup kind of work done DO NOT use retire	pation during most of v	vorking	16b.	Kind of Business/In	dustry	
212	s withir jiene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	-)		tered Nu				Hospital		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be multiled at Once.	To Be C	17. Father's Name (First, Middle, Last) Robert Walter Brook	ce		0		18. Mother's N	lame (First, Middl ha Lee B	e, Maide	on Sumame)		
			19a. Informant's Name/Relationship (Type Mr. William B. Jone								or Town, State, Zip , MD 2140		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Rec 4 Donation 5 Other (Specify)	moval from State	20b. Place com Fore	st Hi	sition (Name of natory or other place 11 Cemet		Date 7/2006	Nas	Location - City or To	IC	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee		1	1					ral and C tain, NC	remations 27804	
			23a. Part : Enter the disease, or complications shock, or heart lailure. List only one	ations that caused cause on each lin	the death. e.	Do not ent	er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ <u>U+</u>	erin	2	conc	ec	· Marini		2	months	
ľ	Examiner		Sequentially list conditions b.	Due to (or as a	consequer	nce or):							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequer	nce ol):							
68760,	ite be (lysicial	edical	L d.										
			IF FEMALE:		,								
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 SNo 9 Unknown	c. II yes, outcome of the common of the comm	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	y			23d. Date of delive Month	ery D <i>a</i> y Year	
Б	es that I	by Ph	Part II. Other significant conditions conti	ributing to death bu	it not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to the	he cause of death?	
ord	w require been sig should b								- 10	Yes :	2 5 40 3 □ Prot	pably 4 Unknown	
I Records,		Completed								opsy formed?	prior to co death?	psy lindings available impletion of cause of 2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:			. 217.00A Ott	105	Death (Check only				
ot	Phys r this ral di	n; To	1 Yes 2 No	1 ☐ Inpatier 28a. Date of Injur	y 2	NOutpatier 8b. Time of	IL 3L DOA	4 Nursing	Home 5 Res 28d. Describe		6 ☐Other (Specification occurred)	y)	
sion	Attending I r death. ector: After by the funer	atio	1 SaNatural 5 ☐ Pending investigation	(Month, Day	rear)	Injury		Yes 2□No					
Division	tal or Attenders after death	Certification;	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)							al Route Number,			
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Exemine	cien: To the best of er: On the basis of and manner sta	examination	edge, deat n and/or in	vestigation, in my o	opinion, death o	ace, and due to the courred at the time	, date a	nd place, and due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title Certifier	22 10			29c. Licens	6 2-06/ S		29d. D	ate signed (Month,	Day, Year)	
2			30. Name and address of person who con	Mille		(3a) (Type				ادلا	42,2	00 6	
	(3)			MALLE	RM			Leisure	world	Slvel	Silver S	Spring Maryla.	
	Sta Regist		JUN 0 6 2006	32. Registra	o Grinatui	Dosa	Les .						

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Susan Rebecca F. Kepler 2:00 A 2006 June, /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Homewood at Crumland Farms Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1□M 2\ F Yrs. 89 3/21/1917 Maryland Director 215-14-2244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show West 1 ☐ Yes 文♥No Falling Waters Director Berkeley Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral', or items 23a or Evaniner must be r United States 25419 48 Climbing Ivy Lane Completed by Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3X Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 7 is marked other than "nature traumatic event, It e Medical 15. Decedent's Education
(Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. ant: if item 27 is marked other than School Teacher 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Leatherman Albert Flook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Climbing Ivy Lane, Falling Waters, WV, 25419 Department of Health ar Important: If item 27 is any injury or other traisons. Vince Kepler / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Middletown, Maryland Zion Lutheran Cemetery 6/6/2006 22. Name and Address of Facility Stauffer Funeral Home 21, Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 complications that caus leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Rant. Enter the disease of complications the shock, or heart failure. List only one cause of Inset and Death Physician disease or condition resulting in death) /Medical of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or in jury that initiated events resulting in death) Last consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): nding physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 2 🗆 No 3 Probably 4 Unknown es Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Certification: To Manner of Dath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29b. Signature an 0 30. Name and address of person who com eted cause of death (Item 23a) (Type, Print) 0 ath 300 hederick sistrar's Signature Registrar

Please Type or Print in Black Indelible Ink

Josue Andres Rivera Lagos State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 11, 2006 0125 hrs Medical Examiner JOSUE ANDRES LAGOS RIVERA 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Montgomery 1700 University Boulevard West Silver Spring 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Age (In yrs. last birthday) **Funeral** Months Days Hours Min oreign Director Country) Honduras 1 **X**M 2 NONE 30 Yrs 08/25/1975 Usual Residence of Decedent 3ny IOc. City, Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No MD Montgomery Silver Spring Director 10e Street and Number Og. Citizen of What Country? 10f. Zip Code 11514 GEORGIA AVE, NW 20902 HONDURAS items 23a Funeral 11 Marital Status Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 X No Yes 0. 1 X Yes 2 No specify: HONDURAS Divorced f Yes, Give Year Specify HISPANIC "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life DO NOT use retired) Elementary/Secondary (0-12) other than MD 21215-0036 Compli should be filed within and Mental Hygiene 6th CARPENTER CONSTRUCTION, CO. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be filt iment of Health and Mental H tant: If item 27 is marked ANDRES LAGOS AGUEDA RIVERA 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEJANDRINA FLORES (Friend) 11514 GEORGIA AVE NW. SILVER SPRING, MD 20902. 20b Place of Disposition (Name of cemetery, 20a Method of Disposition 20c Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 MUNICIPAL 06/12/2006 CORTES, HONDURAS. Donation 5 Other/Specify 22. Name and Address of Facility SANTA CRUZ SREVICIOS FUNERARIOS, INC. 21. Signature of Fundal c 600 KENNEDY ST, NW. WASHINGTON, DC 20011 23a. Part I. Enter the disease, or complication Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line Between Onset and /Medical a Asphyxia and Blunt Force injuries Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause ruisease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical UNPENDED the attending physician led for use as the burial AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð Yes 2 V No 3 Probably 4 Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 28a. Date of injury (Month Day Year) FOUND: Manner of Death 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted Natural FOUND: Yes 2 V No 5 Pending Director: May 11, 2006 0125 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1700 University Boulevard West, Silver Spring, (Specify) Parking Lot determined 4 V Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 24, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 5

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** DOROTHY LYTTLE 11:45₽ [™] 05/26/2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CRESCENT CITY CENTER RIVERDALE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours 577-30-9282 Director 83 12/27/1922 ROCK HILL, SC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itema 23s or 28s-f show Examiner must be notified at tv Yes 2 □ No MD PRINCE GEORGE'S KETTERING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10741 CAMPUS WAY SOUTH 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AM No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: þ If Yes, Give Year or Dates: Specity: BLACK XX Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH CASHIER WONDER BREAD BAKERY other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental marked BETSY DAVENPORT ٩ THOM McELWAIN of Health and hitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10741 CAMPUS WAY SOUTH KETTERING, MD 20774 CASSANDRA LYTTLE / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of HIMportant: If ite any injury or ot 000ce. 1XX Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) FORT LINCOLN CEMETERY 06/05/2006 BRENTWOOD, MD 21. Signature of Funeral Service Licenses MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition relevancelas Dasease **Physician** years ANTERIOSCIPNOTIZ resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō Day Year 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been Decubitus ULCERS 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ē Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 218-5 who completed cause of death (Item 23a) (Type, Print) WSBURY Rd Hyattsville MD 2. Registrar's Signature 31. Date liled (Month, Day, Year) State JUN 0 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** May 29, 11:40p M Mary Christine Littleton 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan. 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF Yrs. 52 1954 Cheverly, Md. 217-60-6988 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Capiotl Heights Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6866 Walker Mill RD. #301 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gladys Hall William A. Littleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6868 Walker Mill Rd. #202 Capitol Heights, Md. 20747 Lakeisha Littleton/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial June 3,2006 Landover, Md. 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, M. A. 20747 21. Signatura of Funeral Service Licentsee Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Finat disease or condition resulting in death) Metastatic Hepatocellular Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2√No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural

To the Hospital or Attending Physician: The law requires thet the death certificate be executed nding physiclen end use as the burial-tran Division of Vital Records, P.O. Box 68760 atter for u s been signed b certificete this After thi death. Director:

Funeral

Director

r then "naturel", or iteme 23a or 28e-f ehow the Medical Examinar nust be notified at

Pages 1 and 2 should be filed within 72 hours after ment of Heelih and Mental Hyglene.
ant: if item 27 is marked other then "naturel", or ite ury or other traumatic event, the Mudical Examina

permit. Page Depertment o Important: if eny injury or ence.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

with the Maryland

deeth

Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dauce(e) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

JUN 0 6 2006

OKONKU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

ā

within 24 hours aft To the Funerei Di completely filled in

Sylvester Okonkwo, M.D. 6192 Oxon Hill Rd. Ste. 507 Oxon Hill, Md.

0055314

May 30, 2006

			1 - State State Registrer	of Maryland /		artment of H		nd Mental Hy	giene	006	9142
			Decedent's Name (First, Middle, Last)					2. Date of D	eath	.,	3. Time of Death
П	Physici /Medic		Richard Clay L:	itchfield				May	30,	2006	9:15 A M
7	Examin		4a. Facility Name (If not institution, give street and n	umber)	Ī	4b. City, Town, or	Location of	Death	4c. Co	unty of Death	
	is a B		Anne Arundel Medical Co	enter		Annapo1			Ann	ne Arur	nde1
	Funeral		5. Social Security Number 6. Sex 1 ₩ 2 □ F	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)	9. Birth Cou	place (State or Foreign intry)
	· Director	į.	246-96-1/85	51	Yrs.			Dec 24	, 1954	Nor	th Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
	f sho	5	Maryland Prince George								1 X Yes 2 □ No
	28a-	Directo	10e. Street and Number	2 DOMIE	-	10f. Zip Code			10a Citizea	of What Cou	ntn/2
	with 3a or	ā	3717 Irongate Lane			20715			U.S.		into y :
	ma 2:	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S.	13. V	1	ispanic Origin	n? (Specify Yes or N		Race - Ameri	can Indian.
0	r tter		1 Never Married 2 Married 1 ∑ Yes	orces? 2 □ No		_		n? (Specify Yes or N Puerto Rican, etc.)		Black, White,	
3	rat', c	l by	3 ☐ Widowed 4 🛣 Divorced If Ŷes, G Year or	Dates: 1976–96	1	☐ Yes 2∏ No	Specify:		Sp	ecity: W	hite
ည	72 hours efter death with the Maryland natural', or terne 23a or 28a-f show cisal Examinat must be natified at	Completed	15. Decedent's Education (Specify only highest grade completed	168	a. Deced	ent's Usual Occupa	ation	of working	16b. Kind	of Business/Ir	ndustry
7	ithin Je.	npi		(1-4or 5+)		kind of work done of OO NOT use retired				rtment	of
2	lygier her th	S	6	S	Syste	ems Analy			Defe		
Maryland 21215-0036	ould be filed within 72 hours efter death with the Marylan Mental Hygiene. arked other than "naturat", or ttema 23a or 28a-f show arked other, the Madical Examinet must be notified at	Be	17. Father's Name (First, Middle, Last)			ĺ		s Name (First, Middle		,	
$\frac{8}{5}$	should and Men marke umatic	7	Guy Tucker Litchfield					la Virgini			
ā	12 st h and 7 ia n treun		19a. Informant's Name/Relationship (Type, Print) Amber Kaye Litchfield/Da					or Rural Route Numb			
	is 1 end 2 of Health a item 27 is other tree		20a. Method of Disposition					cive, Bowi			
Baltimore,	Pages 1 end 2 should brent of Health and Ment: int: if item 27 is marked iry or other treumatics		1 X Burial 2 ☐ Cremation 3 ☐ Removal from	Clate		sition (Name of natory or other place				ion - City or T	
	rtmen rtant		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Maryl		Veterans		02/2006 Robert E.	Chelt	enham,	Maryland
g	permit. Page Depertment of Important: If any injury or once.		ahar Chairle	/				Road, Bow			
-	N 250		23a. Part1. Enter the disease, or complications that	caused the death. Do						Тутани	Approximate
	DI		shock, or heart failure. List only one cause on	each line.	8		_				Interval Between Onset and Death
Î â	Physician /Medical		disease or condition resulting in death)	Neumania o (or as a consequence		Kespiva	+	-ailue			
	Examiner										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence	of):						
	outed id ansit	ımır	Cause (Disease or injury that initiated events c.								
Š	be executed icien and burial-transli	resulting in death) Last Due to (or as a consequence of):									
09/8	% S	dical	d								
Õ	leath certificate ettending phys i for use as the	do l	IF FEMALE:								
XOR	ath ce ttend	an/	23h Was decedent pregnant 23c. If yes, or	utcome of pregnancy birth 2 Petal death	h 3□	Ectopic pregnancy			23d.	Date of delive	,
0	0 0 0	Physician/M	1 Yes 2 No 9 Unknown 9 Unk	gnant at time of death nown	5 🗆	Other (specify)				Month	Day Year
<u>.</u>	requires that the de seen signed by the e hould be detached f	Phy	Part II. Other significant conditions contributing to	doath but not consisting	in the	dashda- as as is	- i- P- 41	22- Pid			
Vital Records,	signe d be d	i by					en in Partt.		Tes 2 □ N		he cause of death?
Ö	w require been si should t	Completed	Pulmenary Emboli	1 1	<u></u>	1 443 5	-			- 3 Fiot	oably 4 ∐Unknown
ě	8 6	ηpi	Lett Lower Exter	mid) IS	che	Linia.		24a. Was	psy	prior to co	psy findings available impletion of cause of
ᇤ	: The cate h							pend 1 ☐ Yes	ormed? 2 ☑ No	death? 1 ☐ Yes	2 🗆 No
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5	Phys this rai di	: To	1 162 5 KMO 15	Inpatient 2 ER/O	utpatient Time of		4 🗀 Nursi	ng Home 5 ☐ Resi			(y)
	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending (Mo		Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	28d. Describe	now injury oc	curred	
<u>s</u>	deat deat ctor: y the	lica	3 Suicide 6 Could not be 390 Place	e of Injury - At home, fa	arm etre		162 2 140		Stroot and M	umbor or Due	al Route Number.
DIVISION	after Dire	Certification:	4 Homicide determined 2.56. Flat	ding, etc. (Specify)	arri, stre	ot, raciory, office		City or To	wn, State)	umber or Hura	ar noute Namber,
	spite nours nerai	aic	29a. Certifier 1 Certifying Physician: To the	ie best of my knowledg	e, death	occurred at the tim	ne. date and o	place, and due to the	cause(s) and	manner as s	tated
	ne Ho	edicai	2 Medical Examiner: On the	basis of examination ar nner stated.	nd/or inv	estigation, in my op	pinion, death	occurred at the time,	date and pla	ce, and due to	the cause(s)
	To the Hospitel or Attanding Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct or the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date si	gned (Month,	Day, Year)
		<			>	0 0009	5879	77	513	e loc	
			30. Name and address of person who completed cau	use of death (Item 23a)	(Type, F	2-1-43			Α.		
			HOWARD YOUNG M		c Ar	undel M	reèlie	& Centr	Ann	apol 15	MD 240
	Sta Registr		31. Date filed (Month, Day, Year) 32.	Pigistrar's Signature		and a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 06 2006 21:00 Dessie Letona McCarty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital
5. Social Security Number 6. Sex 7. Hagerstown
Inder Tyear | If Under 24 Hrs. | Washington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 □ M 2 💢 F Months Hours 91 Yrs. Director January 11,1915 MD 215-20-8781 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County wode in then "natural", or iteme 23a or 28a-f ehovers. The Modical Examiner must be notified at 1 XYes 2 No Directo MD Washigton Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other then "natural", or Iteme 23a eny Injury or other traumatic event, the Mudical Examples and BORS. 9 South Street 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Manager Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory Thompson Pearl Mitchell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Old 126 Warfordsburg, PA 17267 Ruth Ann Golden/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Orchard Ridge Cemetery 06/13/06 Hancock, MD 21. So ature of Funeral Service Like 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only ene tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonio 0 /Medical Due to (or as a consequence of): **Examiner** Avenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit Due to (or as a consequence of): ettending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗹 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by sete has been signed page 2'should be 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death | Check only one Hospital: 1 tient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No After this funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28b. Time of Injury 5 Pending investigation t Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

the Hospital or Attending Physicien: The law requires that the death certificate be executed P.O. Division of Vital Records, ospital v.
4 hours after dea.
-ral Director: After To the Funeral Direct
To the Funeral Direct

with the Maryland

21215-0036

Baltimore, Maryland

Box 68760,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 1 6 2006

29b. Signature and title of certifier

Waselm

29a. Certifier (Check only one)

> 126 O pal 32. Registrar's Signature 1126

30. Name and address of person who completed cause of deat (Item 23a) (Type, Print)

Cour

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MATTHEWS DOROTHY Ε. 12:10 P M JUNE 8 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 94 578-10-9393 2/13/1911 WEST **VIRGINIA** Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23e or 28e-f show other traumetic evant, the Medical Examinarr-wat be notified at 1 ☐ Yes XX No BERKELEY GERRARDSTOWN Director WV 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2781 CHEYENNE'S TRAIL 25420 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itan any injury or other traumetic event, the Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN HOLDER MOLLY PARKS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY H. MATTHEWS/SON P.O. BOX 640, GERRARDSTOWN, WV 25420 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State JUNE 1X Burial 2 Cremation 3 Removal from State ROSEDALE CEMETERY MARTINSBURG, WV 12, 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Siaux 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnam 3 Ectopic pregnancy in the past 12 mor Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo E.O. 9 Unknown 23e. Did tobacco use contribute to the sause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ pe (MATTHEWS, Dorothy 3 To Tobably 1 ☐ Yes 2 ☐ No Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Peath (Check only one) Other: 2 No 4 Urursing Home 1 Yes Certification: To 1. Inpatient 2 ☐ ER/Outpatient — 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To tha Funeral Diractor: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death 28b. Time of atural 5 | Pending 1 Tes 2 No investigation Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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Year)

2006

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2, 2006 **Physician** Shirley Marge 8:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Cherry Lane Perryville Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) De Laware **Funeral** 1□M 2፟MF Months Days 221-28-4557 60 1945 Director November Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinations of the page 2006. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Director Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ll Cherry Lane 21903 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Galbraith Mary Kimsey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy S. Marge Perryville, MD ll Cherry Lane 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 2. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State North East, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) North East Methodist 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Eso phage of): Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ffusion, Albege Rhinitis 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other. 4 Nursing Home 5 A Residence 6 Other (Specify) After this c funeral dire Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jerelme Arms D0044373 6/05 2006 30. Name and address of person with empleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Registrar

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31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760

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			State of Maryland / De		ental Hygier	1e2006 1011.6
				ertificate of Death	Reg. I	
	Physici	an	1. Decedent's Name (First, Middle, Last)			3. Time of Death
	/Medic	al	Theresa Ann Mumey 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JUYE 1	2006 08:19 A M
	Examin	er	Union Hospital of Cecil Courty	C. I. C. L.	,	4c. County of Death
200	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	
	Director		214-38-4875 15 25 65 Yrs.	Months Davs Hours Min.	(Month, Day, Yea Uqust 27	.1940 VA
-	D .		Usual Residence of Decedent			
	aryla shov	7	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1
	the N	Director	MD Cecil Rising 10e. Street and Number	Sun 101. Zip Code	10-	
	after death with the Maryland or items 23s or 28s-f show iminer must be notitied st		115 Turtle Back Ct.			Citizen of What Country?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	21911 3. Was Decedent of Hispanic Origin? (Spec	rty Yes or No-	SA 14. Race - American Indian,
0	after or ite		t ☐ Never Married 2 Married 1 ☐ Yes 2 Mo	If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	Black, White, etc.
3	ours ral',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify: White
5	"natu	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of working	16b.	Kind of Business/Industry
7	withir ane. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) edical Billing		Thortmant Contai
Z Z	be filed within 72 hours after death with the Maryla tal Hygiene. d other than "natural", or items 23a or 28a-f shov event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)	18. Mother's Name (Treatment Center
מום	should be filed within 72 hours after nd Mental Hygiene. marked other than "naturel", or ite matic event, the Medical Examine.	To Be	Peyton Oakes	Evelyn N		,
	s 1 and 2 should I f Health and Meni Item 27 is marke- other traumatic	-		illing Address (Street and Number or Rural I		y or Town, State, Zip Code)
M,	and 2		Thomas Mumey/husband 115	Turtle Back Ct., Ri	sina Sun	. MD 21911
	of He of He fitem roth		1 Burial 2 VCromation 2 Demoval from State	ornatory or other place)	0006	
	Pag ment ant: I		4 □Donation 5 □Other (Specify) R.T. Foo	ard Funeral Home. P.	A. 1	Rising Sun, MD
<u> </u>	permit. Pages 1 am Depertment of Heall Important: If Itam 2 any Injury or other once.		21. Signature of Funeral Service Licenson	22. Name and Address of Facility R.T.	Foard Fu	ineral Home. P.A.
	40 = 4 d		Tuchard A. Gorde	III S. Lueen Street,	Rising S	Sun, MD 21911
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line. Immediate/Cause (Final			Approximate Interval Between Onset and Death
独	Physician /Medical		disease of condition resulting in death)	Hyonary Embol	<i></i>	60001
	Examiner		Due to (or as a consequence of):	and through cyto		6 d . , 1
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	14.000 19 10	peria	0 0 0 0 0 0
	cuted	Examiner	that initiated events			
Š	e exe ten ar urial-t		resulting in death) Last Due to (or as a consequence of):			
	The law requires that the death certificate be executed at the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	d			
מ אמ	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
0	atten for u	Physician/Me	in the past 12 months?	B Ectopic pregnancy Discrete Control of the Control		23d. Date of delivery Month Day Year
j	the d y the	ysk	1 ☐ Yes 20 No 9 ☐ Unknown 9 ☐ Unknown	on other (specify)		
7	s that ned b e deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ž	quire an sig	ed t	Right Veyricular Strain		1 🗆 Yes	2 No 3 Probably 4 Unknown
ecoras,	law re as be 2 sho	ompleted by	Acute parenegtitis		24a. Was an	24b. Were autopsy findings available
5		Com			autopsy performed 1 Yes 2 N	
[0]	cian: ertific actor,	Be (25. Was case referred to medical examiner?	26. Place of Death (
5	Physician: The law this certificate has al director, page 2 (2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati			6 □Other (Specify)
=	Attending Ph ar death. ector: Atter th by the funeral	lon	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	d. Describe how inj	ury occurred
NISIOII	death death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined each of the could not be determined and the could not be determined.		f Location (Street	and Number or Rural Route Number,
2	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	street, ractory, office	City or Town, Sta	te)
	spita hours marel y fille		29a. Certifier Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
	To the To the Complex complex	Ž	29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)
			afec Fix my	D0055190	J	vue 2,2006
			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) EIKtoy LYD 219		116-07
	3 Sta	10	31. Date filed (Month, Day, Year) 1 32. Registrar's Signature	EIKTOY WO CIG	21671	Titled Fino 40
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

RT

Gregory Eugene Millington

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar			Certific	cate of	Death			Reg. No	o. 🔑	UU	0 111
Physicia		1. Decedent's Name (First, Midd	le,Last)						2. Date of I Month	eath Day	Vac		3. Time of Death
Medical Examir	ner	Gregory Eugen	e Milli	ngto	on				May 27	, 2006°	Yea 	"	2018 hrs
		4a Facility Name (if not institution	n, give street and			4	b. City, Town, or I	ocation of D	eath		c. County o		
	*	Southern Maryland Ho	ospital				Clinton				Prince G	0	
Funeral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs last bi	rthday)	If Under 1 Year	If Under 24				9. Birth	place (State or
Director		579-66-2448	1X M 2 F	5.5	5	Yrs	Months Days	Hours	Min. July	5,	1950	Cou	Washington DC
-	h	Usual Residence of Decedent		1									20
any	ſ	10a. State 10b. County	George'		10c. City, Tow		on						10d. Inside City Limits
nd Show	_	MD Prince	George	5	Landovi	C.T.							1XX Yes 2 No
e Maryland or 28a-f show any fied at once.	둜	10e. Street and Number			<u> </u>		10f. Zip Code	-			tizen of Wh		
he M	Director	7232 Tamo Ct					20785			Uni	ted S	tate	S
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene ked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		11. Marital Status	12. Was D	ecedent	t Ever in U.S.	13. Was	Decedent of Hisp	panic Origin?	(Specify Yes or	No-	14. Race	- Americ	an Indian, Black,
eath item	Funeral	1 Never Married 2 M	arried Armed	Forces'	? No	If Y∈	es, specify Cuban,	Mexican, Pu	ierto Rican, etc.)		White	e, etc.	
fter d		3 Widowed 4 X Div	orced If Yes, Give			1	Yes 2 K No	specify:			Specify.	B1a	ck
urs a	d b	15. Decedent's Education (Spe	or Dates cify only highest g	rade cor	mpleted) 16a		's Usual Occupati			16b.	Kind of Bu	siness/Ir	ndustry
72 ho	e	Elementary/Secondary (0-12)	College	(1-4 or	5+) M		ost of working life. arrier	DO NOT use	e retired)		overni	mant	
036 Ithin 72 ne r than	Completed	12	4		I M.	all C	arrier			0	OVELI	iien c	
5-0 ed w lygie other	أق	17. Father's Name (First, Middle,	, Last)						lame (First, Midd Mae Ha)	
21215-00) ould be filed with I Mental Hygiene marked other it	Be	Eugene Byrd						MITITE	rae na	TITO	OII		
5 m e c -	卢	19a. Informant's Name/Relations	hip (Type, Print)		7	9b. Mailing	Address (Street	and Number	or Rural Route I	Number, (City or Town	n, State,	Zip Code)
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene m 27 is marked other than aumatic event, the Medica		Forcina James	/Sister						:1 MD 20	705			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene trant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner.		20a. Method of Disposition		l faces O4	crema	atory or oth	tion (Name of center place)	netery,	Date	20c	Location -	City or 7	Town, State
MOI Pages ent of rt: 1	П	1 X Burial 2 Cremation 4 Donation 5 Other S		i irom St	Quant	ico N	ational	T ₁	ine 6, 2	006	Tria	no1e	Va
nit. F nit. F artme ortal	- 1	21 Signature of Funeral Service)	l'Ceme	22. N	ame and Address	of Facilit P	pe Tune	ra		iigie	V 62
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If iten 27 is mijury or other traumatic.		Xalonas	MAL	w	7	261	7 Penn A	ve SE	Washing	ton	DC 20	020	
Physician		23a Part I Enter the disease, or		t caused	the death. Do i	not enter th	e mode of dying,	such as cardi	ac or respiratory	arrest, sh	nock, or hea	art	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		Drug	Veranar	mil and	l Metoproli	il) into	nxication				Between Onset and Death
Examiner		or condition resulting in death)			equence of).	and the	recopror		ZIZCZCZOII				
ا مود		Sequentially list conditions,	b										
	ner	if any, leading to immediate cause. Enter Underlying Cause		s a cons	equence of):								
	Examiner	(Disease or injury that initiated	С.	s a cons	sequence of):								
ted I		events resulting in death) Last	d.	3 4 00113	equerioe ory.								
ficate be executed ficate be used by physician and the burial - transit	n/Medical	X UNPENDED	AMENDE	o it	em#23a.2	7.28a-f	perme, G	356.6/23	3/06 TT				
60, e be	e	IF FEMALE.			me of pregnanc		7.		,	To	Od Data of	44144.	
8760, tificate being physic as the bur	N S	23b. Was decedent pregnant in t	ho	e birth	ine of pregnanc	y 2 Fet	al death 3	Ectopic pre	egnancy	2	3d Date of Month	D	ay Y ear
x 6 h cert rendii	sicia	past 12 months?	, ,	egnant a	t time of death		ner (Specify)						
Box 6: he death cert the attendir	Phys	1 Yes 2 No 9 Un	known 9 Un	known	w								
d by	<u>a</u>	Part II. Other significant condition	tions contributing	g to deat	th but not resulti	ing in the u	nderlying cause g	iven in Part I.	23e, D	d tobacco	use contri	bute to tl	ne cause of death?
res th	d b	Hypertensive	Heart Di <i>s</i> e	ase,	Schizophi	renia			_ 1 _	Yes 2	No 3	Proba	ably 4 🗹 Unknown
ords, w requir s been s should	Completed								24a. W	as an itopsy			opsy findings available ompletion of cause of
e law	E								pe	rformed?	d	eath?	
tal Rec		25. Was case referred to medica	<u> </u>				26 Place	of Death (Ch	1 V Ye	s Z	No 1	✓ Yes	2 No
ital	8	examiner?	Hospital:	Innatio	ent 2 V ER/	Outpatient		Othor:	ursing Home 5	Resid	lence 6	Other:	
Division of Vital Records, P.O tal or Attending Physician: The law requires that its after death al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detact	ျ	1 Yes 2 No 27. Manner of Death	28a. Da	ate of Inj		. Time of Ir		y at Work?	28d Descri				
n of Iding Pt h : After e funeral	Certification:	1 Natural 5 Pen	(Mo	inth, Day,	Year)	17:00		es 2 X No					
Vision or Atten filter death Olirector:	cati		stigation				t, factory, office be		24 17 1-2	n /Street	and Numbe	er or Pur	al_Route Number, City
Divi	Ħ	dete	ld not be (Speci		Found: pr			ulluling, etc.	Tow	State)	9135 Bu	rton	Court
Dispital ospital hours a nueral K	ပ္ပ	4 Homicide	1,0000	-									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Futueral Director: After this certificate has been signed by the attending physician and completely filled in by the futueral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Exa	hysician: To the laminer:On the bas										
To t. with To t	led	29b Signature and title of certific	and manne	er stated			29c. License						th, Day, Year)
	2	255 Oldinature and title of certifi	-		1)00								in, Day, (Cal)
		Talous a	ronce	e .	-Toll	lus	0.C.N	VI. E.		IVIE	ıy 28, 20	00	
		30. Name and address of person					111 D- C	enat D. W	NAD C1	204			
VP	15	Patricia Aronica-Polla			Medica! Exa	miner	111 Penn St	reet, Baltir	more, MD 21	ZUT			
	ate	31. Date filed (Month, Day, Year)		Registra	ar's Signature	hou	25						
Regist	ıсц	JUN 1 4	LUUU KA	ALL A	1	No.							

			1 - For State Registrar	State of	Marylar	nd / Depa		t of H	ealth a	and Mei	ntal Hyg	giene Jieg, No.	006	19148
-	Physici	an	Decedent's Name (First, Midd							2.	Date of Dea Month		Year	3. Time of Death
	/Medi		*	McDonald						Ma	ıy :	20, Day 20		3:50 рм
4	Examir	ner	4a. Facility Name (If not institution			hah			Location of	of Death			unty of Death	
			St. Thomas No. Social Security Number		. Age (In yrs.		If Under		ille	24 Hrs. 8	Date of Birth		ince G	
	Funeral Director		578-08-7176 Usual Residence of Decedent	1∭M 2□F	73	Yrs.	Months	Days	Hours	Min. 0.5	Date of Birth (Month, Day -29-1	, Year) 932	Washi	lace (State or Foreign http://ngton, D.C.
	yland		10a. State 10b. County	1	10c. Cit	ty, Town or Lo	ocation						1	0d. Inside City Limits
	e Mar	ctor	D.C.			Wa	shing	ton						1 XYes 2 No
	with th	Dire	10e. Street and Number	XT T.T			10f. Zip		\ 1			_	of What Cour	itry?
	s 236	era	429 O Street, 1	12. Was Deced	last Ever in II	c 13		2000		inin? (Specify	Voc er Ne		Race - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Itams 23e or 28e-f show importent: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other treumatic avant, I're Medical Eracin at right of an once.	Completed by Funeral Director	1 Never Married 2 Mail 3 Widowed 4 Divorce	ried 1 Tes Sive	es? 2 X No		If Yes, spec			igin? (Specify n, Puerto Ric	an, etc.)]	Black, White, ec <i>ify:</i> Whi	etc.
Š	2 hou	ted	15. Deceder	nt's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind o	of Business/Inc	dustry
21215-0036	thin 7	nple.	(Specify only night Elementary/Secondary (0-12)	est grade completed) College (1-	4or 5+)					t of working				
21	filed withi Hygiene. other than ant, tre M	Sol	Special Edu.			Speci	al Ed	ucat					Lal Edu	cation
Maryland	ould be fil Mental H larked oth	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name <i>(F</i>	irst, Middle,	Maiden Sur	mame)	
ž	should nd Men marke	ဌ	unk 19a. Informant's Name/Relation	ship (Type Print)		19b Mailir	na Address	(Street a		ar or Rum I R	oute Numbe	r City or To	wn State Zin	Codel
Z Z	and 2 sealth ar n 27 ls		Mary Hinds/case			429 O Washi	Stre	et,	N.W.	0001		, 0.1, 0. 10	wn, State, Zip	3330)
ē,	s 1 ar if Hea itam otha		20a. Method of Disposition		20b. F	Place of Dispo				Date			on - City or To	
Ë	Page nent c int: If iry or		1 ☐ Burial 2 【X Cremation `4 ☐ Donation 5 ☐ Other (later	esapeal	ke Cre	emat	ory J	June 1	,2006	Belts	ville,	Md.
Baltimore,	permit. Pages 1 Department of H Importent: If its any injury or ot		21. Signature of Funeral Service	Licensee Bacon.	CC 3									e, Inc. C. 20010
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the deat ch line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	Pn	eum	onia								Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):								
В	Examiner	<u></u>	Sequentially list conditions,	b. Due to (o	r as a conseq	mence of).								
	ned nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	4	. 43 4 001136q	1401100 017.								
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	uence of):				_				
760,	ite be iysicia ne bur	ical		d.										
68	ing ph as th	Med	IF FEMALE:											
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of d	ıl death 3 [Ectopic pre Other (spe					23d.	Date of delive Month	ry Day Year
Records, P.	uires that t n signed by ild be deta	Completed by Ph	Part II. Dther significant condit			culting in the u	nderlying ca	ause give	on in Part I.		23e. Did to			e cause of death?
000	s been si	olete	U	J							24a. Was a		4b. Were autor	osy findings available
æ	The lav	шо									autops perform	med? 2 \(\subseteq \text{No} \)	death?	npletion of cause of
Vital		Be C	25. Was case referred to medica	al					26. Place	of Death (C			1 103	20,140
of V		To	examiner? 1 Yes 2 No		patient 2	ER/Outpatier	it 3□ DO	A Othe	1. 4 Nu	rsing Home	5 🗆 Reside	ence 6 🗆	Other (Specify)
	ng offer une		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury		8c. Injury Work	at ?	28d	. Describe h			
Sio	Attanding r death. sctor: After by the fune	cat	2 Accident invest 3 Suicide 6 Could	not be	Claires AAA		М		/es 2□l		1			
Division	ital or Attandi rs after death. ral Diractor: A led in by the fi	Certification;	4 Homicide determ	buildin	of Injury - At higg, etc. (Specif	ý) 					City or Town	n, State)		Route Number,
	To the Hospital or Attanwithin 24 hours after deatl To the Funaral Diractor:	Medical	one)	ng Physician: To the t Examiner: On the bas and manne	sis of examina	owledge, death	vestigation,	in my op	oinion, dea	d place, and th occurred a	due to the cat the time, d	ause(s) and ate and plac	I manner as stoce, and due to	ated. the cause(s)
)	To the within To the Comple	2	29b. Signature and title of certific	rates.	W		29c.	License	215.	24	2	9d. Date sig	gned (Month, L 5 06	Day, Year)
2			30. Name and address of person	who completed cause	of death (Item	n 23a) (Туре, ~	Print) 1160	VA	RNO	um s	T. NE	= , U	UPC.	20017
	Sta Regist	ate rar	31. Date filed (Month, Day, Year JUN 0 5	2006	gistrar's Signa	Ature	de							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) June 3, 2008 5:08 A Jovita Estanislao Margallo Margallo **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 12 NF 82 June 16, 1923 Philippines | Director 218-49-2352 Usual Residence of Decedent 10d. toside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-1 show or Items 23s or 28s-f show 1 ☐ Yes % ☑ No Prince George's Ft. Washington Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 USA 7905 Carey Branch Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportent: if item 27 is marked other than "naturel", or iter any injury or other treumatic event, the Modical Exar. if was any injury or other treumatic event, the Modical Exar. if was any 1 ☐ Never Married 2 ☐ Married Specify: Filipino 1 Yes XX No Specify: Baltimore, Maryland 21215-0036 δ 3€XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) In Home 8 Homemaker 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brigido Maigue Estanislao Anastacia Peralta Regaldo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7905 Carey Branch Drive Ft. Washington, Maryland 20744 Allan Margallo / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) / June 6, 2006 Gate of Heaven Cemetery Wheaton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20/45 21. Signature of Funeral Service License Part 1. Enter the disease, or contrications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIORESPIRATORY ARREST **Physician** /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine DIABETES MELLITUS The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes XX No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 1 Yes 2 No 3 Probably 4√ Unknown Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 2□ No 1 ☐ Yes 1 Tyes this certificate or Attending Physicien: rector. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir 28b. Time of Injury Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death filled in by the within 24 hours after deat To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number Make ne D0009162 6-5-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6196 Oxon Hill Road #250 Oxon Hill, Maryland 20745 MD Jafar Nazemian 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar JUN 0 5 2006

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year P^{M} **Physician** 04 2006 7:50 06 Kathryn Munro /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Atlantic General Hospital 8. Date of Birth (Month, Day, Year) 11/26/1917 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 21X F Yrs. 88 577-03-4854 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event. I've Mudical Examinational be notified at 1 ☐ Yes 2X No Directo Berlin MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 5 Sloop Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married XX Married 1 Yes 2 XNo Specify: Maryland 21215-0036 Specify: White δ 3 Widowed 4 Divorced n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theria Bohland Peter Harich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 5 Sloop Lane, Berlin, MD 21811 nt of Health it if item 27 I ä Leslie Munro Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury of once. 6/8/2006 Suitland, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ 9ther (Specify) Fun Service Lice see 22. Name and Address of Facility The Burbage Funeral Home 108 WIlliam St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAMBIONASCULAR BISEASE Pnysician MITTEROSCIENORC /Medical Due le (or as a consequence of): Examiner MERTENSIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit RENAZ INSURGUENCY IMONIC. Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Vital Hospitel or Attending Physiclen: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Munico 1 1 Inpatient 3□ DOA 1 Yes 2 No 2 ER/Outpatient 2 o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To tha 29d. Date signed (Month, Day, Year, algnature and title of certifier Leceaso 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWIN CASIMEDAINO 10324 020 OCEAN CAM BLUD. BERLIN, MD 21811 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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JUN 0 5 2006

			1 - State of Ma	ryland / I		artment of H rtificate of L			iene 2	006	5 1915
ı			Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physici /Medic		Elmer Preston METZ, Sr.				j	June 5	, 2006	Year	7:35 p. M
1	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death		4c. Count	y of Death	
			142 Buttercup Drive			Hagers	stown		Was	hingt	on
	Funeral		150 N 200	(In yrs. last bii	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
ı.	Director		214-07-2626 Usual Residence of Decedent	93	Yrs.			Oct. 2	1912		ýland
	and and			10c. City, Tow	m or Lo	cation					I Od. Inside City Limits
	Mary fehi	to	Maryland Washington	На	oer	stown					1 ☐ Yes 2 🖾 No
	28a	Director	10e. Street and Number		-60-	10f. Zip Code			0g. Citizen of	What Cour	ntry?
	be filed within 72 hours after death with the Maryland nat Hygiene. All Hygiene. Other than "natural", or iteme 23a or 28a-f show event, the Medical Exendrate must be notified at	i D	142 Buttercup Drive			217	740		US		
	me 2	Funeral	11. Marital Status 12. Was Decedent Ev	er in U.S.	13. V	Was Decedent of His	spanic Origin? (Spe	cify Yes or No-		ce - Americ	
9	after or ite		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No				n, Mexican, Puerto F	Rican, etc.)		ick, White,	etc.
3	rel',	d by	3 ∰ Widowed 4 □ Divorced If Yes, Give Year or Dates:	WWII		I□Yes 2⊠ No	Specify:		Speci	fy: W	hite
5	72 h 'natu	Completed	 Decedent's Education (Specify only highest grade completed) 	16a	Deced	lent's Usual Occupa kind of work done d	ition furing most of workin	ng l	16b. Kind of B	Business/In	dustry
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	e d ia	Be	Lewis Westley Metz					t Hoope		,	
	houk d Me mark matic	မှ	19a. Informant's Name/Relationship (Type, Print)	19h	Mailin	a Address /Street a					Code) 21502
2	end 2 s eeith an n 27 is ser treu		Larry Boggs, Executor								erland,Md.
בֿ	9 9 5 5		20a. Method of Disposition	20b. Place of	f Dispos	sition (Name of	Di		20c. Location		
2	permit. Pages: Department of the Important: If Ite any injury or of any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place.'s Cemete			Rouzer	-	
	artm ortar injui		21. Signature of Funeral Service Licensee				s of Facility MIN				, 14.
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ı			23a. Part1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each ina	ne death. Do							Approximate
	Physician		Immediate Cause (Final	ona	99	Juin 6	reary	(ailu	re		Interval Between Onset and Death
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	icate be executed physicien and s the burial-transit	dicai	d								
>	ding page as	•	IF FEMALE:	D.C.							
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5	at the de by the c tached	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tir 9 ☐ Unknown 9 ☐ Unknown	ne or death	2□	Other (specify)					,
_	The law requires that the death certif site hes been signed by the ettending page 2 should be detached for use a		Part II. Other significant conditions contributing to death but	not resulting in	the un	derlying cause give	n in Part I.	23e. Did tob	acco use cont	ribute to th	e cause of death?
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-	Physician: r this certifice ral director,	0	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient	2 ER/Ou	toationt	Otho	26. Place of Death		001	(0 (
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	Atte	E E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, fa	rm, stre	et, factory, office	28	Bf. Location (Str	eet and Numb	er or Rural	Route Number,
5	s after or	Certification:	building, etc.	(Spaciny)				City or Town	Siale)		
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	cai	29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of each of the second page 1	my knowledge	, death	occurred at the time	e, date and place, ar	nd due to the ca	use(s) and ma	nner as sta	ated.
	the hin 24	Medical	and manner state	d.							
	Viti Viti	-	29b. Signature and fitte of certifier	M.T	$\overline{}$	29c. License	number	3 1 29	d. Date signe	d (Month, E	Jay, Year)
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<i>\ 11</i>	linti		30. Name and address of person who complèted cluse of dea	th (Item 23a) (Type, P		+ DOGI	C = . 1	L LA	ALLON ON	ELANIA
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		-	For State Registrar	State of Ma	ryland /	Depa Cer	artment o <i>tificate</i>	of Healt of Dea	th and		iene 2 (06	1915
			Decedent's Name (First, Middle, Last)							2. Date of Deat Month		Year	3. Time of Death
	Physicia /Medic	al	Ronald Haywood Mi							June	4 ac	06	7:50 P.M.
	Examin	er	4a. Facility Name (If not institution, give s				4b. City, To	m, or Local 'stown		th	4c. County of Wash i		n n
			Washington County 5. Social Security Number 6. Sex		(In yrs. last	hirthday)	If Under 1 \		nder 24 Hr	s. 8. Date of Birth			lace (State or Foreign
	Funeral Director			14 00 5	73	Yrs.	Months D	ays Hou	urs Min	8. Date of Birth (Month, Day, August	Year) 5.1932	Coun	(land
	D		Usual Residence of Decedent		10a City T								0d. Inside City Limits
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	the M 28a-1	ecto	10e. Street and Number	///	Ondi	pobul	10f. Zip Co	de		1	0g. Citizen of W	hat Cour	ntry?
	3a or	Ö	112 E. Antietam St.				,	21782			USA		
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9	or its	y Fu	1 Never Married 2000 Married	1. Yes 2 No If Yes, Give		-	1 ☐ Yes 2)		ecify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		whit	
Ş	within 72 hours after death with the Maryland ene. than "natural", or ferms 23e or 28e-f ehow fre Medical Examiran must be codified at	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	1955	6a Decec	dent's Usual C	ccupation			16b. Kind of Bu		
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ē,	Heal	1	20a. Method of Disposition		20b. Place	of Dispo	sition (Name natory or othe	of	1		20c. Location - (
E E	Pages nent of int: if i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		Cemeter		06-0	09-2006	Sh ar psbu	ırg,N	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, the Madical Examinating Institutial at ODEs.		21. Signature of Funeral Sce incepte	QL	_					sborne Fu ue St. W			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each line	the death. [Do not ent	er the mode o	f dying, suc	h as cardi	ac or respiratory arr	est,		Approximate Interval Between
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9	death certificate be executed e attending physicien and nd for use as the burial-transit	/Mec	IF FEMALE:	3c. If yes, outcome of	of pregnancy	,					and Date	ا ما ماماند	
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Division of Vital Records,	i or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	iry - At home :. (Specify)	, larm, str	eet, factory, o	ffice		281. Location (Si City or Town		er or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin		examination								
	To the To the Comple	₩.	29b. Signature and title of certifier	/			29c. L	icense num	ber	2	9d. Date signed	(Month,	Day, Year)
			Mayneted				D	325	18		1/05/0		
101	411+1		30. Name and address of person who co	mpleted cause of de	eath (Item 23	Ba) (Type,	Print) Kee	Lysn	rele	ind	2/75	2	
	Sta Regist		31. Date liled (Month, Day, Year)	32. Registra	er's Signatur	A	reste	0					

DHMH 17 Rev 1/2001

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	Physici		1. Decedent's Name (First, Middle, La Lester Harold ME	•						2. Date of De Month	Day	Year 2000	3. Time of Death		
1	/Medic Examir		4a. Facility Name (If not institution, gi						Location of Dea		4c. Cou	nty of Death			
						last birthday)		er 1 Year	Stown If Under 24 Hr	s. 8. Date of Bir	th	shing			
	Funeral Director		214-34-0172	1⊠M 2□F	69	Yrs.		Days	Hours Mir		, Year) , 1937	Ma	place (State or Foreign intry) aryland		
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits		
	Ba-f el	ector	Maryland Washi	ngton		Нав	erst						1X Yes 2 No		
	3a or 2	i Dire	10e. Street and Number 605 Ravenwood	Drive			10f. Z	ip Code	21740		10g. Citizen USA	of What Cou	intry?		
	me 2	era	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13.	Was Dec	edent of H	ispanic Origin? (Specify Yes or No rto Rican, etc.)		Race - Amer			
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, the Medical Enatural must be invitted at ance.	by Funeral Director	1 Never Married 21 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No			ecify Cuba 2∑ No		rto Rican, etc.)	1	Black, White cify: W	, etc. hite		
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	end 2 ealth a n 27 is		Audrey Mentzer	- wife					od Drive		stown,	Md. 2	21740		
Baltimore,	ages 1 nt of He :: # Iter		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3			lace of Dispo				Date /06		on - City or T			
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DHMH 17 Rev 1/2001

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		_ For	State of Ma		d / Dep	artment of I	Health and	_		•	10151
		- Stata Ragistrar			Ce	rtificate of	Death		Reg. No	.4 4 4 6	19134
Physici /Medic		1. Decedent's Name (First, Middle, La: Charles Richa						2. Date of D Month	eath Da		3. Time of Death 2253 M
Examin		4a. Fecility Name (If not institution, give		1	, ,	4b. City, Town,	or Location of Dea		40	. County of Dea	th
			reneral	HUS	pital	Carr	If Under 24 Hr	e		Lord	nester
Funeral Director		210-70-7013		8	ast birthday Yrs.) If Under 1 Year Months Days			year year	958 Mar	thplace (State or Foreign ountry) Yland
land land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Charter Mayland with the Mayland or 28a-1 show we multified at	by Funeral Director	Maryland Dorches 10e. Street and Number	ter			Linkwood			10g Ci	tizen of What Co	1 Tyes 2 No
23aor	Ö	3621 Bonnie La	ne			218	35				USA
death with	era	11. Marital Status	12. Was Decedent	Ever in U	S. 13	Was Decedent of If Yes, specify Cut		Specify Yes or N	lo-	14. Race - Ame	erican Indian,
, <u>a</u>	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐			1 ☐ Yes 2 ☐ No	/	to Hican, etc.)		Black, Whi	•
21215-0036 d within 72 hours after giene. set than "naturat", or ite	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				_,			Specify: Wh	
72 h 72 h 42 d 45 d 45 d 45 d 45 d 45 d 45 d 45 d	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo	rking	16b. F	(ind of Business	/Industry
2 12 Within 18 18 18 18 18 18 18 18 18 18 18 18 18	шb	Elementary/Secondary (0-12)	College (1-4or	5+)					,	776. 1	,
nd 21215-003 be filed within 72 hours tal Hyglene. d other than "natural; event, the Medical Exp	ပိ	12 17. Father's Name (First, Middle, Last,)		wate	man/cons	T	me (First, Middl	_		<u>construction</u>
d dala	o Be	Samuel Thomas		•				a Mae Ho			
larylar 2 should bh and Ments is marked aumatic e	은	19a. Informant's Name/Relationship (19b. Mai	ing Address (Stree					Zip Code)
~ ~ ~ ~ ~ ~ ~		JoAnn Murphy/Spo	use		362	21 Bonnie	Lane, L	inkwood,	MD	21835	
ore, M es 1 and 27 of Health	. 3	20a. Method of Disposition	3B	20b. F	lace of Disp emetery, cri	osition (Name of amatory or other pla	100)	Date	20c. L	ocation - City or	Town, State
altimor mit. Pages partment of portant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif				Cremation		6/03/200)6 Ca	ambridge	e, MD
Baltimol permit. Pages Department of important: if i		Signature of Funeral Service Licer	(- PONK	WE	eal	2. Name and Addr urran-Br 308 High	ess of Facility OMWell F	meral H	Home,	21613	÷
- Tarte B	1	23a, 'art1. Enter he disc se, or com shock, or he in fature. List only	one cause on each li	the deat	h. Do not er	nter the mode of dy	ing, such as cardia	c or respiratory	arrest,	21010	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			e n	ce phalo	rathy				Onset and Death
/Medical		resulting in death)	Due to (or as	a conseq	uence of):	cephalo	1				
Examiner		Securation list conditions				Lung Co	aucer				
P P P	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consec	uence of):	0					
ecute and trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2 000000	uance of):						
60, be executed sician and burial-transit	al E		Due to (or as	a conseq	derice or).						
			d								
Box 687 auth certificate attending phys for use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome	of pregna	ancy					23d. Date of de	livery
Bo Beath atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnand □ Other (specify) _	У			Month	Day Year
P.O. nat the d	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
p, P	by Pt	Part II. Other significant conditions	contributing to death b	out not res	ulting in the	underlying cause g	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
of Vital Records, Physician: The law requires t								11	Yes 2	□No 3□P	robably 4 Unknown
aw ren	Completed							24a. Wa		24b. Were a	utopsy findings available
Re It	mo							auto peri 1 □ Yes	opsy formed?	death?	completion of cause of
ital	0	25. Was case referred to medical					26. Place of De	ath (Check only		,	20110
f Vi ysici	To B	examiner?	Hospital:	ent 2	ER/Outpatie	ent 3 DOA	her: 4 Nursing	Home 5□Res	sidence	6 ☐Other (Spe	ocify)
n of ng Physical Internal Inte		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	iry y Year)	28b. Time Injury	of 28c. Inju	iry at	28d. Describe	how inju	ry occurred	
SiOI endir sath. or: Al	atlc	2 ☐ Accident investigatio	n]Yes 2□No				
Division for Attending after death. Director: After din by the fune	Certification:	3 Suicide 6 Could not be determined		jury - At h ic. <i>(Speci</i> l	ome, farm, s	treet, factory, office			(Street a. own, Stat		ural Route Number,
D oital o oral D	Ce							<u> </u>			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 ☐ Certifying P! (Check only one) 2 ☐ Medicel Exer	hysician: To the best miner: On the basis of and manner st	f examina	wiedge, dea	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s e, date an	d place, and due	s stated. e to the cause(s)
To t To t com	Σ	29b. Signature and title of certifier	100 recol				se number			ite signed (Moni	
		• Na	~ (w) V			124	7924		2 -	30-06	
		30. Name and address of person who					C A	0.0	~ 1	216	17
	ate	31. Date filed (Month, Days Kear)				STREET	CAMIS	RIBGE	1 1	210	′)
Regist		JUN 9	2006 ^{32. Re}	Car.	Dr.	post					

			_ For_				Depa	artmen	t of H	ealth a	and M	lental Hy		e o o o		0 1 5 7
			1 - State Registrar				Ce	rtificat	e of L	Death			Reg. No	2006)	15
	Physicia	an	1. Decedent's Name (First, Midd Julia Ann	_{10, Lasi)} 1a McCan	n							2. Date of De Month May 3		^{1y} 2006 ^{Year}	6:01	of Death
	/Medic Examin		4a. Facility Name (If not institution					4b. City,	Town, or	Location o	of Death	nay 3		County of Deat		4
	≥xamin		Chester River			1thca:	ce	Ches	ster	town			K	Cent		
	Funeral		5. Social Security Number	6. Sex 1 M 2	7. Age	(In yrs. last t		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 4,	th y, Year	9. Birt	hplace (State	or Foreign
li.	Director		183-30-7756 Usual Residence of Decedent	1 M 2 M	1	67	Yrs.					Dct.4,	193	88 F10	rida	
	land ow		10a. State 10b. Count	,		10c. City, To	wn or Lo	ocation							10d. Inside	City Limits
)	Mary e-f sh	tor	MD Kent	;		Chest	tert	town							1 □ Y€	es 2 🔀 No
5	death with the Maryland ims 23a or 28e-f show	Director	10e. Street and Number					10f. Zip	Code				_	itizen of What Co	untry?	
3	ath wi	rai	9868 Worton						620					SA		
3	items items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Ma		cedent E Forces? 2 X N		13.	Was Deced	dent of Hi cify Cuba	spanic Ori n. Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.))+	14. Race - Ame Black, Whit		
20	hours after turei', or ite	by	3 ☐ Widowed 4 ②CDivorce	If Vas (Sive			1 🗆 Yes	2 1 No	Specify:				Specify: Wh	ite	
9500-61212		Completed	15. Decede	nt's Education est grade completes	4)	16	a. Dece	dent's Usua	al Occupa	ation during mos	t of worki	ina	16b. F	Cind of Business/	Industry	
7	within 72 ene. than "na'	mpie	Elementary/Secondary (0-12)	1	(1-4or 5-	+)		kind of wo				9	II.a	. and L = 1		
	filed w Hygier other tl	Co	11 17. Father's Name (First, Middle	Last)			ноп	ıseke	epe		r's Name	(First, Middle		spital		
Maryland	id be f ental h ked of	To Be	Russell LaV									Anna H		,		
ar	s 1 and 2 should f Health and Men item 27 is marke other treumatic	-	19a. Informant's Name/Relation			19	9b. Maili	ng Address	(Street a	and Numbe	or or Rura	ai Route Numb	er, City	or Town, State, 2	Zip Code)	
	1 and 2 Health a tem 27 is		Donald Crew									tertow	n,	MD 21	620	
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal fro	n State	20b. Place cemer	of Dispo tery, cre	osition (Nar matory or o	ne of ther place	θ)		Date	20c. L	ocation - City or	Town, State	
	permit. Pages Department of Importent: if it any injury or o ance.		*4 ☑Donation 5 ☐ Other (Specify)		Anato					/30/			over, 1		and
a a	permit Depar impor impor any in		21. Signature of Funeral Service	Licensee		>						_		al Home		612
			23a. Part 1. Enter the disease, of shock for heart failure. Lis	r complications tha	caused	the death. De								idge, 1	Approxim	ate
	Dhusisian		Immediate Cause (Final											1000	Onset and	
	Physician /Medical		disease or condition resulting in death)			consequence		in u	JUTE	1 00	NE_	META	+51	/t >(= 2	715	gear
	Examiner		Sequentially list conditions	b												
	sit sd	iner	Sequentially list conditions, it any, bearing to introduce cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (oras a	s dunsequend	e of):									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	ç	o (or as a	a consequenc	e of):									
9	ysician ysician	caiE		d												
S S				- 0.												
XOR	eath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetal dea	th 3[⊒Ectopic pr	regnancy					23d. Date of del	ivery Day	Year
о п	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pre 9□Unl		time of death	5 [Other (sp	ecify)					WOITH	Day	roat
٦.	that the de led by the a detached t		Part II. Other significant condit	ions contributing to	death bu	ıt not resulting	in the u	inderlying c	ause give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of	f death?
ďg	uires tha signed lid be del	d by										1 🗆	Yes 2	1 0 3 □ Pr	obably 4	_Unknown
Hecords,	w require s been si should b	Completed										24a. Was		24b. Were au	itopsy finding	s available
	The lav	шо					_					autoj perfo	psy ormed? 2 X No	death?	completion of 2 No	cause of
Vital		Bec	25. Was case referred to medic examiner?	ai						26. Place	of Death	(Check only				
o t	hyeic this ce al dire	ုင	1 ☐ Yes 2 No		Inpatier			nt 3 DC	_	4 200				6 Other (Spec	cify)	
	iding Phyeicien: th. : After this certifica funeral director, p	ion:	27. Manner of Death 1 Natural 5 ☐ Pend	ng (Me	e of Injur onth, Day	Year) 28b	Injury	f 2	28c. Injury Work	rat ⊲? Yes 2.⊟i		28d. Describe	how inju	iry occurred		
Division	i or Attend after death Director: /	ficat	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Inju	ıry - At home,	farm, st			165 2	-	28f. Location (Street a	nd Number or Ru	ıra i Route Nu	ımber,
≧	after I Dire	Certification:	4 Homicide	bui	lding, etc	ry - At home, :. (Specify)		, , , ,				City or To	wn, State	ө)		
	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific; completely filled in by the funeral director,		29a. Certifier Certify (Check only 2 Medice	ng Physicien: To t I Exeminer: On the	he best of	of my knowled	ge, deat	h occurred	at the tim	ne, date an	d place,	and due to the	cause(s	and manner as	stated.	(0)
	the H the F the F nplete	Medical	one)	and ma	anner sta	ted.		-								
	7 Vill		29b. Signature and title of certification	7 MM	le	_ hi	D	250	D	004	158	37	250. 00	5 - 31 -	2001	_
			30. Name and address of perso	who completed ce	use of de	ath (Itam 22	(Type	Print)	200					- 01		
			Helen A. M	10/-1- N	1 7	12	25,	oeer	Ro	ad	Sui	16.5	CI	hestert.	DW 1.1	nD
	Sta		31. Date filed (Month, Day, Yea	0 1 2006 ³²	Registra	ur's Signature	BR	Marie	KI				, ,	ate signed (Month 5-31- Besterf		
	Registi	ar	JUN	A T SAGA		Service d	Cho o	15			,					

			1 - For State Registrar	State of Marylan		artment rtificate			nd Me	-	giene Reg. No.	2006	191	5 (
₹31	Physici	an	Decedent's Name (First, Middle, Last						1	2. Date of De Month	ath Day	Year	3. Time of De	ath
	/Medic	al	James Ben 4a. Facility Name (If not institution, give	jamin Noble,	Jr.	4h City 1	Fown or I	Location of		May 2	25,	2006 ounty of Death	8:58	Р
	Examin	er	Southern Maryland	·			intor		Death			rince G	norgo	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under		If Under 24	4 Hrs. 8	B. Date of Bird (Month, Da	h		place (State or Fintry)	oreign
	Director		577-96-5328 Usual Residence of Decedent	∄м 2□ F 34	Yrs.	Monda	Duys	Tiodis	_		, 197		h. DC.	
	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City L	_imits
	a-feh	ctor	Maryland Prince G	eorge T	emple 1	Hills							1 X Yes 2	□No
	ath with the Marylar 1238 or 288-f ehow 1881 te notified at	Olre	10e, Street and Number			10f. Zip					10g. Citize	n of What Cou	ntry?	
	sath w	eral	3083 Brinkley Rd		C 40.1	W Dd)748	.0.40	4 14 11		d Stat		
_	fter de	Funeral Directo	11. Marital Status 1⊠ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.5.	Yes, speci	ent of His ify Cuban	, Mexican,	Puerto Ri	ify Yes or No ican, etc.)	14.	Race - Ameri Black, White,		
2-003p	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ehow rdical Expiral neat be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			Sį	pecify: Bla	ick	
ה	"natu	Completed	15. Decedent's Edu (Specify only highest grad		/Give	ent's Usual	k done di	ion iring most o	of working	,	16b. Kind	of Business/In	dustry	
7	within 72 ene. than "na!	dmc	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		sabled					No	n Appl	iaabla	
<u>D</u>	a filed Il Hygid other	Be C	17. Father's Name (First, Middle, Last)					18. Mother:	's Name (First, Middle,			ICable	
yiand	Mental Merked c	To E	James Noble					Step	phani	e Wils	on			
Mar	12 sho	1 9	19a. Informant's Name/Relationship (T) Stephanie Noble									own, State, Zip	Code) Md. 207	11.0
ō,	s 1 and if Health item 27 other tr		20a, Method of Disposition		Place of Dispo				Da:	_		tion - City or To		40
Ē	Pages ment of lant: If it		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Idilioval Ilolli State				l l	ına 2	2006		ton, M		
a	partm ports y inju		21. Signature of Funeral Service Licens							e Fune Forest				
מ	83558		Jua J	illely								, MD.	20747	
			23a. Part . Enter the disease, or compleshock, or heart failure. List only of	ications that c au sed the death ne cause on each line.	h. Do not ente	er the mode	of dying,	such as ca	ardiac or i	respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a/	17/	090	70	Em	-			4	ntinos	/
	Examiner			Due to (or as a conseq	Lit	2 h	iel	PR	7				ntines	
	p i	Iner	E aquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							P		~~
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	uance of):									
ζ Q		Ical E		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	dence or).									
00	certificate oding phys	ed		J										
X D D	th cert tendin r use	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pre	nancy				23d	I. Date of delive	,	
	it the death certific by the ettending p lached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of do		Other (spe						Month	Day Year	,
Ţ.	law requires thet the death as been signed by the etter 2 should be detached for t	Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying ca	use given	in Part I.		23e. Did to	bacco use	contribute to the	ne cause of deat	 n?
n S	w requires thet s been signed b should be deta	ed by							_		es 2 🗆 N			_
၂ ၁	law re	Completed								24a. Was			psy findings avai	
Ē	The The page	E C			- w - -					autop perfor 1 Yes		death?	mpletion of cause 2□ No	3 OT
\ [a]	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	lospital:					of Death (Check only or	18)			
5	Physic this stal dil	2	1 Yes 2 16	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of			4 Li Nursi		d. Describe h		Other (Specificular)	y)	
VISION	nding ath. r: Afte e func	atlor	1	(Month, Day Year)	Injury	м	ic. Injury a Work? 1 □ Ye	s 2 □No			,,,,,			
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory,	office		28	f. Location (S City or Tow	treet and N n, State)	lumber or Rura	l Route Number,	
ב	pital o		29a. Certifier Cartifying Phys	delen T. M. Land										
	To the Hospital or Attending Physician: The law within 24 burus elier death, within 24 burus elector-atte fro the Funerel Director-Atten this completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medical	(Check only 2 Madical Exami	sician: To the best of my kno- ner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at estigation, i	t the time in my opir	, date and p nion, death	place, and occurred	d due to the d at the time, d	ause(s) and late and pla	d manner as st ace, and due to	ated. the cause(s)	
	within To the compl	Me	29b. Signature and title of certifier	,		29c.	License r					igned (Month,		
			1 / CAL	21		S	6	(5	1		Mar	7,26	,66	
)	(5)		/ /	m cause of death (Item	23a) (Type, I	Print)		0 1	-	001		Jo 26		
	Sta	te.	Ravinder W. Sindhw 31. Date filed (Mogth, Day, Year)	anily of Ceo	zy - F	tue 3	-41	اللا	600 S	PRIF	MDZ	8136		
	Registr.		JUN 0 6 2006	Blown K	hour	٠.								

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Faustino Ortiz 24, May 2006 8:56 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07-10-1948 9. Birthplace (State or Foreign Country) Dominican Rep. **Funeral** Months 1 X M 2 ☐ F Director 215-31-5758 57 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f ehow 10d. Inside City Limits Maryland Prince George's Directo 1 Yes 2 □ No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Iteme 23a or Examiner must be Dominican Republic 629 Sheridan Street #2B 20783 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Itimore, Maryland 21215-0036 1X Yes 2□ No Specify:Dominican 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Poretsky other then College (1-4or 5+) Porter 6th Management 27 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Menta! Geronimo Ortiz Clara D. Lopez ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 629 Sheridan Street #2B Pages 1 and 2 Raquel Ortiz/daughter Hyattsville, Maryland, 20783 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 In Cremation 3 □ Removal from State Depertment of Important: If any Injury or one. Chesapeake Crematory | 05-30-2006 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. h. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHAONIC OBSTRUCTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine been signed by the ettending physicien and should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) Year P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Records, ۾ 2 1No Completed 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate Division of Vital 1 ☐ Yes 2 ☐ No 1□ Yes 2 PNo : After this certification of funeral director, p 8 25. Was case referred to me scale examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 7No 2 ER/Outpatient 1 Inpatient 3 DOA 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred or Attending 1 Natural To the muserum within 24 hours after death.

To the Funeral Director: Aft Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGIA AVE 31. Date filed (Month, Day, Year) State JUN 0 5 2006 Registrar

		1 - For State Registrar	State of M	aryland / De		ent of He ate of D		nd Menta		ene2 (106	19158
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Exar	mine				1	ty, Town, or		Death			y of Death	00***
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ife, Marylatha Z I Z I D-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show offen fraumatic event, II's Moulcal Examiner must be notified at	hv Filnera	1 ☐ Never Married 2 ☐ Mar	Armed Forces? 1 ☐ Yes 2 ☐	No	-	pecify Cubar 2√∑ No	, Mexican, F Specify:	n? (Specify Ye Puerto Rican, e	etc.)		ick, White,	etc.
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2 short and is my		19a. Informant's Name/Relations						or Rural Route				743
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VILAI F sician: Th certificate rector, pag	O	25. Was case referred to medica	1				26 Place of	Death Check	Yes 2	8-No	1 🗌 Yes	2□ No
90	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 🕝 ER/Outpati	ent 3	Other		ng Home 5	100	e 6 Oth	er (Specifi	4
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To the Hospital or within 24 hours affect to the Funeral Direction completely filled in in	edical (ng Physician: To the best Examiner: On the basis of and manner sta	examination and/or	ath occurre	ed at the time on, in my opii	, date and p nion, death o	place, and due occurred at the	to the caus time, date	se(s) and ma and place,	anner as stand due to	ated. the cause(s)
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(4)		30. Name and address of person	who completed cause of d	ath (Item 23a) (Typ	e, Print)		- / ~			J, - 0	122	
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			1- For State of Maryland / Department	artment of Health and M rtificate of Death		giene 2006	19159
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month May 30	Day 2006 Year	3. Time of Death
y)	/Media	cal	Mary Catherine Purdum 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 30		4:40 AM
	Examir	ier	Carroll Hospital Center	Westminster		4c. County of Deat	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birti (Month, Day		hplace (State or Foreign
	Director		220-18-3309 1 M 2X F 80 Yrs.	Months Days Hours Min.		, 1925 Mai	ryland
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	Maryl	Į.	MD Carroll Mt. Airy				1 Tes 2 No
	r 28s	lrec	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
	23a c	alD	713 Midway Ave. Apt 228	21771	1	United Stat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow with fully or other traumatic event, the Medical Exart art must be notified at once.	by Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
Š	72 hou	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business/	ite Industry
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altimore,	Pages 1 ment of He ant: If iten ury or oth			sition (Name of natory or other place) Mem. Park 2006	e 2,	20c. Location - City or Sykesville	
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	the Hospital in 24 hours of the Funeral pletely filled	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, a sestigation, in my opinion, death occurred	and due to the ca ed at the time, d	ause(s) and manner as ate and place, and due	stated, to the cause(s)
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-1	9		30. Name and address of person who complete care of death (Item 23a) (Type, GURISHARKAR C, MAGANNA	Print) TOWA POOLE	RD We	ESTMINSTER	RMD21157
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				For State	State of Ma	ryland / D	epartme	nt of H	ealth a		ental Hy	giene	_	5	191	60
				Registrar 1. Decedent's Name (First, Middle, Las	t)		Certifica	ile oi i	Jeam		2. Date of De	Reg. No.			3. Time of	Death
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		/Medic Examin	W	4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of	Death		4c.	County of E	Death		
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()	ar dea	tems ar m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec		ispanic Origi In, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.))-	14. Race - / Black, V	Americar Vhite, et		
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B	anc	ed of	Be C	John Roland Pro							Mary					
2010	Maryland 2	mark mark	٦ ک	19a. Informant's Name/Relationship		19b	. Mailing Addre	ss (Street						te, Zip C	Code)	
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Ď	altimore,	of He fitem r oth		20a. Method of Disposition		20b. Place of cemeter	Disposition (A y, crematory o	lame of r other plac	:ө) 6	-3 ^{Da}	2006	Chia	cation oct	te e	Hall	, MD
0	iim Pa	ment lant: lury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Brins	field						1		·	
1	Ball	Department of Health and Mental Hygiene. Important: if Items 23e or 28e-f ehow important: if Item 27 le marked other than "natural", or Items 23e or 28e-f ehow eny Injury or other traumatic event, tre Medical Eval Lear must be notified at once.		21. Signature of Funeral Service Licer	MO	1458	3019	5 Th	ree N	lotcl	ls Fu h Rd	Char				
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	oertift	nding use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- 55						23d. Date of	f delivery	у	
	Ö death	e atte	iciai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic 5 □ Other		/				Month		Day 1	/ear
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	Division of Vital Records, P.O. Box 68	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by F	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the underlying	g cause giv	en in Part I.				se contribu		cause of d bly 4 □l	
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		10 NE		30. Name and address of person who Manisha J. Jariwa				., St	e. 10	3, Wa	aldorf	. MD	20602	2		
		Sta	ate		2006 32. Segistra											
		Regist	rar	2 0 M 0 2	ZUUD Chille	a D.	COSC.	2								

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*	Funeral Director		5. Social Security Number 6. Se 390–12–0376 10 Usual Residence of Decedent	7. Age (In yrs. la ☐ M 2 1 86	Yrs.	If Under 1 Yea Months Day			rth	9. Birtho	place (State or Foreign http) COnsin
	he Maryland 18e-f show	Director	Maryland Prince Ge	eorge's Gle	, Town or Lo ndale						1 ☐ Yes 2 2 1 No
	sath with the 23a or 3	erai Dir	10e. Street and Number 6820 Hillmeade Road	10 W. D. J. E		10f. Zip Code 2076			10g. Citizen of USA		
9000	72 hours after death with the Maryland natural", or Items 23a or 28e-f show dical Examinations to conflict at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 🗗 No		(Specify Yes or No erto Rican, etc.)	5- 14. Ra Bla Specii	ce - Americ ick, White, fy: Wh	ean Indian, etc. ite
21215-0036	d within 72 t giene. er than "natu	Completed	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	cation (a completed) College (1-4or 5+) 4	(Give life. L	lent's Usual Occu kind of work don DO NOT use retir f Employed	e during most of v ed)	vorking	16b. Kind of B		dustry
Maryland	hould be file d Mental Hy narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) Constantine Mallas 19a. Informant's Name/Relationship (To	ves Orient	405 14 75		Vassil:	^{ame (First, Middle} iki Koseta			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examina must be rediffed at once.		William Pantazes / Gra 20a. Method of Disposition 1 ∰Burial 2 Ø Cremation 3 □ F	andson 20h Pla	6820	Hillmeade		Rural Route Numb Idale, Mary Date 1002/2006	land 20	769 - City or To	wn, State
Baltimore,	permit. Pa Departmen Important: any injury once.		4 □Donation 5 □ Other (Specify) 21. Signaturate Funeral Service Lights		22	. Name and Addr	ess of Facility G	eorge P. Ka Oxon Hill,	laurel, las Funer Maryland	-	e PA
	Pnysician /Medical Examiner		23a. Part / Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ilication that caused the death. ne cause on each line. RENAL Due to (or as a consequence).	Do not ente	PAI C	ing, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
,8760,	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.	ence or):	P	ka n	T P	-141C41	2	
.O. Box 6	The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1	death 3	Ectopic pregnand Other (specify)	y			te of delive	ry Day Year
ords, P	w requires that been signed t should be det		Part II. Other significent conditions con	ntributing to death but not result	ting in the un	derlying cause gi	ven in Part I.				e cause of death?
tal Reco		Completed	25. Was asso referred to medical					1 Yes	rmed?	Were autoporior to comdeath?	osy findings available apletion of cause of
Division of Vital Records,	ding Phys h. After this funeral dir	ation: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		R/Outpatient 8b. Time of Injury	28c. Inju	her: 4 🗆 Nursing	eath (Check only on Home 5 Residence 128d. Describe h			1
Divis	Hospitel or Attender to the control of the control	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical	one)	sician: To the best of my knowledge: ner: On the basis of examination and manner stated.	edge, death n and/or inve	estigation, in my	opinion, death occ	curred at the time, of	date and place, a	and due to	the cause(s)
	5 Wild	<	29b. Signature and title of certifier		_		Se number		June 1,		ay, Year)
R	(4)		30. Name and address of person who co Cecil D. George, M.D.	7525 Greenway C	enter I	rive #1	13 Greenbe	lt, Marylan	nd 20770		
	Sta Registr	_	JUN 0 5 2006	32. Registrar's Signatur	Love	J.					

2. Date of Death

3. Time of Death

3.	1. Decedent's Name (First, Mid	ddle, Last)					
Physician /Medical	MYRTLE						
Examiner	a me no an office a facility	tion, give s					
	LAUREL REGI	ONAL					
Funeral	5. Social Security Number	6. Sex					
Director	271-40-7113	10					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

al - er ⁴	MYRTLE	G. PIPPIN				MAY MAY	26 ^{Day} 2006	9:25 A					
	4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, o	r Location of Death		4c. County of						
	LAUREL REGIONA	L HOSPITAL		LAUREL				E GEORGE'S					
:		Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year)	Birthplace (State or For Country)					
-	271-40-7113	70	Yrs.			JULY 2	5 1935	KENTUCKY					
-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City L					
5	MD PRINCE	GEORGE'S	MITCHEI	LLVILLE				1 X Yes 2[
Director	10e. Street and Number	GEORGE D		10f. Zip Code			10g. Citizen of W	hat Country?					
5	10309 SEA PINES	DRIVE		20721	L		U.S.A.						
2 -	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		- American Indian, c, White, etc.					
Funeral	1 ☐ Never Married 2 ☐ Marned	1 Tes 2 No		Yes 21X No	Specify:	riiodii, otor,	Specify:						
200	3 Widowed 4 Noivorced	Year or Dates:						BLACK					
ompleted	15. Decedent's E (Specify only highest gr		(Give I	lent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Bus	siness/Industry					
E	Elementary/Secondary (0-12)	College (1-4or 5+) 4+		ACHER	2)		GOVERN	MENT					
- ر	17. Father's Name (First, Middle, Lasi	-	112	HOIIII	18. Mother's Nam	e (First, Middle,							
0	WALLACE GILLES					. CARTE		•					
2 -	19a. Informant's Name/Relationship		19b. Mailin	a Address (Street	and Number or Rui			State, Zip Code)					
	ANITA EDWARDS/I			•				MARYLAND 20					
	20a. Method of Disposition	20b. F		sition (Name of		Date	20c. Location - 0	City or Town, State					
	1 ☐ Burial 2 🛣 Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	Hemoval from State		E CREMAT		2006	RIVERDA	LE, MARYLAND					
-	21. Signature of Funeral Service Lice	**		. Name and Addre			NKING FI	INFRAT. HOME					
		7											
-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximation of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	shock, or heart failure. List only Immediate Cause (Final	•	AT TMEA	DOTTON				Onset and Dea					
-	disease or condition resulting in death)	a. MYOCARDIA		IKCITON									
	- (Due to (or as a consec	puerice or).										
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	(uerice of):										
Examin	Cause (Disease of Injury	ASPIRATION	ON PNEU	MONIA									
X	that initiated events resulting in death) Last	c. Due to (or as a consec	juence of):										
		d											
sician/Medical													
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 Live birth 2 Feta		Ectopic pregnance	u.			of delivery					
ic a	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (specify)			Mon	ith Day Yea					
Fnys	9 ☐ Unknown	9L) Unknown					-						
Dy P	Part II. Other significant conditions	-	sulting in the ur	nderlying cause giv	en in Part I.			bute to the cause of deat					
eq		RTERY DISEASE				101	es 2 K No	3 ☐ Probably 4 ☐Unki					
<u>e</u>	ATRIAL FIBI	RILLATION				24a. Was autop	an 24b. W	Vere autopsy findings ava					
Q						perfo	rmed? de	eath? ☐ Yes 2 ^K No					
ошо	25. Was case referred to medical	1			26. Place of Dea		V						
e)		Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott	ner: 4 ☐ Nursing H	ome 5 🗆 Resid	lence 6 🗆 Othe	or (Specify)					
o Re	examiner? 1 Tes 2x No		28h Time of	28c. Injur Woo	ry at	28d. Describe h	ow injury occurre	ed .					
To Be	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury (Month. Day Year)	(Month, Day Year) Injury			28d. Describe now injury occurred							
To Be	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)			Yes 2 □No		ation (Street and Number or Rural Route Number,						
To Be	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year) on be and Bloom of Injury. At h	Injury ome, farm, str	M 1		28f. Location (S City or Tox		or or Rural Route Number					
To Be	1 Ses 2 No 27. Manner of Death 1 Natural 5 Pending investigate 2 Accident investigate 3 Suicide 6 Could not	(Month, Day Year) on be 28e. Place of Injury - At h	Injury ome, farm, str	M 1				or or Rural Route Number					
Certification: To Be	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Continues	(Month, Day Year) be d 28e. Place of Injury - At h building, etc. (Speci	Injury ome, farm, stri fy)	M 1 = eet, factory, office	Yes 2 □No	City or Tox	m, State)	nner as stated					
edical Certification; To Be	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1	(Month, Day Year) be d 28e. Place of Injury - At h building, etc. (Speci	Injury ome, farm, stri fy)	M 1 = eet, factory, office	Yes 2 ☐ No	City or Tow and the to the red at the time,	on, State) State and place, a	nner as stated nd due to the cause(s)					
o Be	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exe	(Month, Day Year) 28e. Place of Injury - At houlding, etc. (Speci	Injury ome, farm, stri fy)	M 1 = eet, factory, office	Yes 2 No	City or Tow and the to the red at the time,	date and place, a	nner as stated and due to the cause(s)					
edical Certification; To Be	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1	(Month, Day Year) 28e. Place of Injury - At houlding, etc. (Speci	Injury ome, farm, stri fy)	M 1 = eet, factory, office	Yes 2 No	City or Tow and the to the red at the time,	date and place, a	nner as stated nd due to the cause(s)					
edical Certification; To Be	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and titlenof certifier 30. Name and address of rerson who	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Special Physician - T. the bast of my limaminer: On the basis of examinand manner stated. Auditorial - T. the bast of my limaminer stated.	Injury ome, farm, str fy) wedge dealt attion and/or inv	M 1 (Yes 2 No	City or Tow	m, State) and mar date and place, a 29d. Date signed MAY 3.	mner 2. Maled and due to the cause(s) (Month. Day, Year) 1, 2006					
edical Certification; To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and titlenof certifier 30. Name and address of rerson who	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Special Physician - To the basis of examinating and manner stated. Multiple - At he basis of examinating manner stated.	Injury ome, farm, stri fy) wedge dealt ation and/or inv m 23a) (Type,	M 1 = eet, factory, office noctured at this in vestigation, in my of 29c. Licens D0052 Print) K DR # 22	Yes 2 No	City or Tow	m, State) and mar date and place, a 29d. Date signed MAY 3.	mner 2. Maled and due to the cause(s) (Month. Day, Year) 1, 2006					

Edin Roberto Quinonez Merlos

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19163

	1 F	- For State Registrar Amend#10b.Pen	FH6-5-06 PG	car C	ertifica	ate of	Death			Re	g. No.		0 1 1 1 0
Physician	1	1. Decedent's Name (First, Middle Edin Roberto	e,Last)						2	2. Date of Deat Month May 24, 20	h Dav	Year	3. Time of Death 2339 hrs
A DOCK		4a. Fecility Name (if not institution 12910 Baltimore Aver	=	imber)		41	o. City, Town, o Laurel	r Location o			Prin	ounty of Deat ICe Georg	e's
Funeral Director		5. Social Security Number None	6. Sex	7. Age (In yrs	s. last birth	nday) Yrs.	If Under 1 Year Months Day			8. Date of Birt 10/31	h(MM/DD/ 1975		rthplace (State or gn puntry) Guatemal a
faryland 28a-f show any at once.		Usual Residence of Decedent 10a. State 10b. County Princ Princ 10e. Street and Number	ce George'	S	ity, Town o					La	Ola City	(10)	10d. Inside City Limits 1 Yes 2 No
i the Maryland		4401 53rd P1	ace				2071	0		10	_	of What Cou	<i>'</i>
	by Funeral	3 Widowed 4 Div	arried Armed Fo	2 No)	If Ye	Decedent of Hi s, specify Cuba Yes 2 No	n, Mexican,	Puerto F	Rican, etc.)		White, etc.	ncan Indian, Black,
136 hin 72 hours e. than "natur edical Exam	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)	Cify only highest grad		16a. I	luring mo	s Usual Occupa st of working life structi	e. DO NOT				of Business	ŕ
e, MD 21215-0036 1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than 's item 27 is marked other than 's Traunal and Trauman To Do Communications and the statement of the	8	3rd. 17. Father's Name (First, Middle Roberto Quin	*							First, Middle, Merlos	laiden Sur		
and 2 should the tealth and Mer tem 27 is mar traumatic event and mer traumatic event event and mer traumatic event event event event event event event event event event even		19a. Informant's Name/Relations Ruth N. Quino			8	510		Ave.	Apt	. 9-в т	acom	a Park	, Md 20912
MOFE Pages 1 ent of H int: If i		20a. Method of Disposition 1 R Burial 2 Cremation 4 Donation 5 Other S	pecify:		cremato	ry or othe	ion (Name of ce er place) Cemeter			Date 06/2006		Guate	r Town, State
	I	21. Signature of Funeral Service	Bell /	S -		Av	e. NW W	ashin	mu gton	D.C. 2	0011		4804 Georgi
Physician Medical xaminer		23a. Pert I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	uries		t enter the	e mode or dying	, such as ca	ardiac or i	respiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b Due to (or as a	consequence	e of):								
ecuted and transit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	e of):				-		_		
a a e	ealcai	UNPENDED	AMENDED								1		
Box 68760, e death certificate be the attending physici ed for use as the buri	Siciany	23b. Was decedent pregnant in the past 12 months?	1 Live b	ant at time of	2		ol death 3 er (Specify)	Ectopic	pregnan	су		ate of deliver	y Day Year
P.O. s that the gned by		Part II. Other significant condit	ions contributing to	death but no	t resulting	in the un	derlying cause	given in Pa	rt I.	pane			the cause of death?
Records, The law requir ficate has been si	Completed									24a. Was a autops perfor	med?	prior to death?	utopsy findings available completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medica					26.Plac	e of Death (Check or	1 Yes 2	· N	1 🗸 Y	es 2 No
of Vital ig Physician ther this certi neral director	o	examiner? 1 Yes 2 No	Hospital: 1	npatient 2	ER/Ou	tpatient	3 DOA	Other ₄	Nursing	Home 5 I	Residence	6 🗸 Othe	er: Scene
ion of tending Ph death. ttor: After t	ation.	27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	28a. Date May 24, stigation	of Injury , Day, Year) , 2006	28b. T 2335	ime of Inj hrs		ıry at Work′ Yes 2 ✔	in/	8d. Describe h lotorcyclist			ce car
Division or spital or Attending fours after death.		3 Suicide 6 Couldete	d not be 28e. Place	e of Injury - At Major Ro			factory, office	building, etc		8f. Location (S or Town, St 2910 Baltin	ate)		ural Route Number, City rel, MD
To the Hos within 24 h To the Fur completely		one 2 Medical Exa	nysician: To the bes miner:On the basis of and manners	of examination			on, în my opinion	n, death occ			ind place,	and due to th	ne cause(s)
	≥/	29b. Signature and title of certific	lesu	eD			O.C.	M.E.				signed (Mo	onth, Day, Year)
2(2)			ssistant Medica	I Examiner	r 111	Penn S	Street, Balti	more, MI	D 2120	1			
Stat Registra	-	31. Date filed (Month, Day, Year)	2006 Re	gistrar's Sign	ature	houl	e de la companya de l						

			For State Registrar		State	of Maryla	and / Depa <i>Ce</i>	artment <i>rtificate</i>			and M	lental H	ygiene Reg. No	6. U	06	19161
	Physic		1. Decedent's Nar FLORE		Last) ITA QUE	EN						2. Date of D Month 05	eath 30	y 20	Year 006	3. Time of Death 9:35 pM
	/Medi Examii				give street and nu			1	own, or	Location o	ol Death		40	. County	of Death	orge's
	Funeral Director		5. Social Security 577–36–	1464	6. Sex 1 □ M 2 □ X	7. Age (In y 80	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 04–16–1	irth			lace (State or Foreign
	Maryland -f ehow lied at	tor	Usual Residence 10a. State MD	10b. County	George's	10c.	City, Town or Lo								11	0d. Inside City Limits YEXYes 2 □ No
	h with the 23s or 28s	at Direc	10e. Street and N 4540 Nat	umber tahala Dr	ive			10f. Zip (ode 0735					tizen ol W	/hat Coun	itry?
980	toes 1 and 2 should be filed within 72 hours after deeth with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at	t by Funeral Director		rried 2 Marrie	Armed Fo	2 □ No ve		Was Decede			gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	Blac	- America k, White, a Black	etc.
Maryland 21215-0036	d within 72 ho gione. ir then "natu	Completed	(Spe		s Education grade completed) College ((Give	dent's Usual kind of work DO NOT use	done di	tion uring most	of worki	ng	16b. K	ind of Bu	siness/Ind	lustry
yland	12 should be filed within in and Mental Hygiene. 7 ie marked other then "raumatic event, the Men	To Be C	17. Father's Name Unkr		ast)							(First, Middle Queen	e, Maiden	Sumam	9)	
	and 2 sho ealth and m 27 ie my	1 1	19a. Informant's f	ueen	Daughter	1	4540	Natah	ala	Drive	e Cl	inton,	MD 2	20735		
Baltimore,	2 5 5 5			2 ☐ Cremation 5 ☐ Other (Sp.	_	State C	Place of Dispo competery, crei neltennam	nation (Name matory or oth MD Vette 2. Name and	er place Tans		06/0)7/2006			City or Tov m, MD	
Ba	permit. Departn imports eny inju)	Pyl			B	ianchi 8	314 U	ipshur	St NV	Wash, 1)11		
,00	Physician /Medical Examiner prize pr	Examiner	shock, or he Immediate Cause disease or condition resulting in death Sequentially list of any, leading to cause. Enter Unc. Cause (Disease of that initiated even resulting in death)	conditions, immediate derlying or injury ts	b Due to	ach line.	equence of):									Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed as been signed by the attending physicien and coge? Should be detached for use es the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow	2 months? √ No		ointh 2 □ Fe nantattime o	etal death 3	Ectopic pred						23d. Date Mon	of deliver	y Day Year
	w requires that been signed t should be deti	<u>م</u>	Part II. Other sign	ificent condition	s contributing to d	eath but not r	esulting in the u	nderlying cau	ise giver	n in Part I.		_			oute to the	e cause of death?
of Vital Records,		e Completed	25. Was case refe		,							24a. Was auto perfo 1 \(\text{Yes}		pr de	or to comeath?	sy findings available pletion of cause of
f Vii	S S	To Be	examiner?	No	Hospital:	npatient 2	☐ ER/Outpatien	t 3 DOA	Other			Check only one 5 ☐ Resi		3 □Other	(Specify)	
Division o	Affer fune	Certification;	27. Manner of Dea 1 Salatural 2 Accident	ath 5 ☐ Pending investiga 6 ☐ Could no	tion	th, Day Year)	28b. Time of Injury	М			2	8d. Describe				
Divi	i Bir o		3 Suicide 4 Homicide	determin	ed 28e. Place buildi	ng, etc. (Spe						City or To	wn, State,)		Route Number,
	4 T T J S	Medicai	29a. Certifier (Check only one)	1⊠ Certifying 2 Medical E	Physician: To the ceminer: On the band man	best of my kasis of examiner stated.	nowledge, death nation and/or inv	occurred at restigation, in	the time my opi	, date and nion, death	l place, a n occurre	nd due to the d at the time,	cause(s) date and	and man place, ar	ner as sta id due to t	ted. the cause(s)
	To the within 2 To the complet	2	29b. Signature and	d title of certifier					icense (,	5_5				(Month, D.	,
2	(5)		Mich	al Sic	langus	e of death (It	em 23a) (Type,	Print)	~ 1) #	± 101	ffa	roshin	Ha	MI	06
	Sta Registr		31. Date filed (Mor	nth, Day, Year) N 0 5 20	06 FL. R	egistrar's Sig	nature	E								
DH	MH 17 Rev 1/2	001					1									

			For State	State of Ma	ryland					lental Hyg	jiene	200	1 (5 1 (4 (44
			Registrar				rtificate	or Dea	2 <i>T</i>	2. Date of Dea	eg. No.	1115	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, La LOUISE	YOUNG	RE	EITE	R			June June	Day	2006	2:00 AM
)] ;	Examir	150	4a. Facility Name (If not institution, giv	e street and number)			4b. City, To	wn, or Loca	tion of Death		4c. Cou	nty of Death	
	Company of	**************************************	Carroll Hospital		(la con la	a d. fe indle nter ch	Wes If Under 1	tmins	ter	8. Date of Birth		rroll	land (State on Familia
*	Funeral Director		215-78-5938	M 2 1 7. Age	9°	st birthday) Yrs.			urs Min.	(Month, Day	, Year)	Coun	lace (State or Foreign try) PA
	and wc		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					1	Od. Inside City Limits
	the Marylar 28a-f ahow notified at	to	MD Carro	011	7	westm:	inster						1 ☐ Yes 2 ⊋No
	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ahow olical Examinatornal be notified at	Funeral Director	10e. Street and Number 1810 Benedict	Road			10f. Zip Co	2115	57	1	-	of What Cour USA	try?
	ms 23	era	11. Marital Status	12. Was Decedent E	ver in U.S	. 13.	Was Deceden	t of Hispani	ic Origin? (Sp	ecify Yes or No-		Race - Americ	
336	irs after	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	İ	1 ☐ Yes 2 5		ecify:	rican, etc.)		Black, White, c <i>ify:</i> Whi	
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	a filec othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. 8	Mother's Nam	e (First, Middle,	Maiden Sum	name)	
/lar	Menta Menta arked	To E	William Young							t McCon			
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than "tor other traumatic event, it is M.		Maryocciakley/Dadig Marie Coakley/daw				ng Address (S Benedi			al Route Number estminste			_
ē,	of Health of Health item 27 i		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Name matory or othe	of er place)	1	Date	20c. Locatio	on - City or To	wn, State
Baltimore			1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci				ige Cen		6/6/2	2006	Balti	more,	MD
alti	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Lice	nsee						and Cha	apel,	P.A.	
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.O. Box 6	death certific e attending p id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of the composition of the comp	2 Fetal	death 3	Ectopic preg Other (speci					Date of delive Month	ry Day Year
ds, P	Se G	d by P≀	Part II. Other significant conditions CHRONIC OBS			-	_		Part I.		bacco use co es 2⊠No		e cause of death?
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Vita	iysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:						h (Check only or			
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no	fte ne	ţi	1 XNatural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	Year)	Injury	м	. Injury at Work? 1 ☐ Yes	2 No				
ivisi	pital or Attending ours after death. ieral Director: After filled in by the fune	Certification:	3 Suicide 6 Could not to determined	OB Place of Inju	iry - At hor :. (Specify)	ne, farm, st	reet, factory, o	office		28f. Location (Si City or Town		mber or Rura	l Route Number,
	To the Hospital or Attendinition 24 hours after death. To the Funeral Director: A completely filled in by the function of the	edicai Ce		hysician: To the best of miner: On the basis of and manner sta	examination								
		Me	29b. Signature and title of certifier	Lelmi. N	1.1		29c. L	icense num	7 695	- 2	9d. Date sig	ned (Month,	2006
7	WSV		29b. Signature and title of certifier 30. Name and address of person who ABDALLAH J. HI	completed cause of de	eath (Item	23a) (Type,	Print) 20	HOSPI	norial	Ave. () ENTER,	Westa	UNSTEI	R, MD 21157
	St	ite	31. Date filed (Month, Day, Year)	32. Pegistra	ır's Signatı	ure							

Registrar

JUN 0 5 2006 | Street &

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear Francis Louis Riddick, Sr. 4:55 P M May 29 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4167 Southern Ave., Capitol Heights Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. Director 154-30-5712 64 Dec. 11, 1941 New Jersey Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location r then "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 XYes 2 No Maryland Prince George's Capitol Heights the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4167 Southern Ave., #102 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ð Specify: Black. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'eny injury or other traumatic event, the Market in the Elementary/Secondary (0-12) College (1-4or 5+) 12th Brick Mason Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Riddick, Sr. Alpha Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 Angela F. Tunnell-Riddick/Wife 4167 Southern Ave., #102, Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 6/06/2006 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) Physician Lung Cancer 10 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading to infractal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Data to (or as a nonsecuanda of): Examine physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as esn. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Records, δ pe Kidney Failure Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy rmed? 2 X No certificate Division of Vital 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 fnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide I Direct d in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

. Registrar's Signature-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce R. Kressel, M.D.

31. Date filed (Month, Day, Year)

JUN 0 5 2006

DC 7655

2141 K St., NW, Suite 707, Wash., DC

June 1, 2006

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 28^{Pay} 2006^{ear} MAY 5:00A **Physician** ROMEO SHIRLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CAPITOL HEIGHTS AVENUE 1008 MENTOR 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 K F 70 WASHINGTON, DC 577-50-9122 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1X Yes 2 □ No Director CAPITOL HEIGHTS PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20743 1008 MENTOR AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE RETAIL 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H fitem 27 is marked oth r other traumatic even pe H. Brooks i. Pages 1 and 2 should be trient of Health and Menta tant: If item 27 is marked jury or other traumatic ex ROBERT LEE HARRISON ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1008 MENTOR AVE CAPITOL HEIGHTS, MARYLAND 20743 DEBORAH STENNETT/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If eny injury or once. LANDOVER, MARYLAND 6/2/2006 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 5 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER NON-SMALL CELL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included support of the conditions) Duy to (or as a sunsequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 2X No 1 Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after death uneral Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title d INDIANA 01056019A MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEELAM ASHAI M.D. 4410 74th AVENUE LANDOVER, MARYLAND 31 Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUN 0 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () (State Registrar Amend#16a.Per FH PCC 6-6-06 cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yeer **Physician** 10:45 AM RICHARD 15HER 2006 lunc /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HUSP1702 BALTIMORE BALTIMORE 5 AM ARITANI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Hours | Min. | Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 2□F 219 07 Director 165 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. Int: If Item 27 is marked other then "natural", or Itame 23a or 28a-1 ehow 10a State 10c. City, Town or Location 10d. Inside City Limits i Health and Mental Hygiene. Item 27 Is marked other then "natural", or Itame 23a or 28a-1 ehov other traumatic event. The Medical Exteriner must be notified at 1XYes 2 □ No Director MID BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 1213 2305 USA-AVE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)_____ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STLAWART 4 CO. Chief 12 yrs. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame To Be WILLIE RISHER EFFIE GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROTHER IOIL URELL PLNE WASH DC 20017 KISHER OUIS. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6/10/2006 BRIENTWOOD MD T. LINCOLN 22. Name and Address of Facility JOHN 7. RHINES 21. Signature of Funeral Service Lice 3015-12th STINE WASH DC Clear Approximate Interval Between Onset and Death 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** NEUMAN IA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed STICIL 4 SHEILAL DECUBITUS ULCION Due to (or as a consequence of): Box 68760, as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) detached Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 30 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. thours after death.

uneral Director: A

sly filled in by the for 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 7 TON DING PHYSICA DOO 62239

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State Registrar 31. Date filed (Month, Day, Year)

JUN 0 6 2006

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NAINU

MAN

30. Name and address a person who completed cause of death (Item 23a) (Type, Print)

SAMARITAN

2. Registrar's Signature

			For State Registrar	State of M		Depa		of He	ealth a		ental Hyg		2006	19169
- 12	ŝ	6.	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea		V	3. Time of Death
	nysicia		FREDERICK A	NTHONY R	ICHARDS	5					Month May	2 7	2006	3:56 AM
	Medic xamin	100	4a. Facility Name (If not institution,				4b. City, T	own, or	Location o	f Death		4c. Cc	ounty of Death	
	A411111		FREDERICK M	EMORIAL J	HOSPITA	AL	FR	EDE	RICK			F	REDER	ICK
	neral ector		5. Social Security Number 214–26–2150		ge (In yrs. last b		If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day OCT. 22	, Year)	9. Birth Cou Mar	place (State or Foreign ntry) yland
and		}	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
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with	3	2	6101 Ridgelin	e Drive				21771	1			Unit		ates
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ter d	100	'n	1 ☐ Never Married 2 ☑ Marrie	Armed Forces	?	1	f Yes, speci	fy Cuban	, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
DOOR af	1	by	3 Widowed 4 Divorced	If Yes, Give	1951-53		1 ☐ Yes 2	X No	Specify:			Sp	pecify:	White
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with a with a signal of the si	2	Completed	12	College (1-40)		lech:	anic					Exxo	n Oil	Co.
If ICL X I X 13-0030 be filed within 72 hours after death with the Maryland by Hygiene.	outer that issuing, or take as a coor enough	Bec	17. Father's Name (First, Middle, L.	ast)					18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)	
Harric Jid be fill Mental Hy	ic	To E	Andrew		Richard	ls			E1s	ie	May	Schla	g	
Should be filed within and Mental Hygiene.	other traumatic	-	19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailir	ng Address ((Street a	nd Numbe	r or Rura	l Route Numbe	r, City or T	own, State, Zij	o Code)
permit. Pages 1 and 2 Department of Health a	ar tra		Marylou Richar	ds / Wife	6	5101	Ridge	eline	e Dr.	/ Mo	unt Air	y, MD	217	71
5 5 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1	oth		20a. Method of Disposition		20b. Place cemet	of Dispo	sition (Name	e of her place	9)		ate	20c. Loca	tion - City or T	own, State
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Phys /Me	dical		disease or condition resulting in death)	a	Hypers saconsequence oftrid	7 O 10	(1774 C							
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Geath certifical	nse	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Efetal dea	h 2	Tetania ava					230	f. Date of deliv	ery
de at a	d for	icia	in the past 12 months?	4□Pregnant	at time of death]Ectopic pre] Other (s <i>p</i> e						Month	Day Year
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Vital H	certificete rector, pag	0	25. Was case referred to medical	1					26. Place	of Death	Check only or		10 163	2010
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	e fun	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		ay sears	Injury	м		: ′es 2 □!	No				
I or Attending after death.	by th	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of I	njury - At home, etc. (Specify)	farm, str	reet, factory,	office			28f. Location (S City or Tow	treet and N	lumber or Run	al Route Number,
S afte	i p	Certification:	4 Tromicide	building, t	віс. (Зреспу)						City of You	r, State)		
pspit	y fille		29a. Certifier 1 Certifying	Physician: To the bes	at of my knowled	ge, deat	h occurred a	at the time	e, date an	d place,	and due to the o	ause(s) an	id manner as s	stated.
n 24	oletel	edical	one)	xaminer: On the basis and manner	or examination a stated.	ind/or in	vestigation,	in my op	inion, deal	th occurr	ed at the time, o	ate and pi	ace, and due t	o the cause(s)
UIVISION OF VITA To the Hospitel or Attending Physician: within 24 hours after death.	comp	×	29b. Signature and title of certifier	mb.			29c.	License	number		ż	9d. Date s	igned (Month,	Day, Year)
	Ω.		As	you mis.			MI	DD 54	4636			May 3	0, 200	6
INX	IM		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,						-		
IL			Syed Haque,	700 W. Se	venth St	. /	Frede	ericl	k, Ma	ry1a	nd 217	01		
445	Sta	te	31. Date filed (Month. Day, Year)	32. P 6is	strar's Signature		Saul.	,						
F.	Registr	ar	JUN 0	C TAND										

			For State Registrar	State of	Marylan		artment of hi rtificate of			Mental Hy	giene 2	006	19170
1		ш	1. Decedent's Name (First, Middle	o, Last)						2. Date of D	eath Day	Year.	3. Time of Death
	Physici /Medic		Jacqueline	L.	•]	Regan			MAY		2006	7:30 A.M.
	Examin		4a. Facility Name (If not institution	, give street and numb	oer)		4b. City, Town, o			•	4c. Cou	inty of Death	
			Baltimore Washi	noton medic	eal Cer	nter	Glen Bu	unie		,		· Arun	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 XX	Age (In yrs.		If Under 1 Year Months Days	If Unde Hours	or 24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)	Cou	place (State or Foreign ntry)
	Director		056-32-8215	TE W ZAIN	66	5 Yrs.				Aug. 2	0, 193	9 New	York
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Manyli feho	ö	MD Anne	Arundel		0den:	ton						1 ☐ Yes 2√No
	the h	ect	10e, Street and Number				10f. Zip Code				10g. Citizen	of What Cou	ntry?
	with se or	<u>ā</u>	529 Patricia	Court			211	113				JSA	
	death with the Maryland me 23a or 28a-f ehow Entrat be notified at	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13.	Was Decedent of I		Origin? (Sp	pecify Yes or N		Race - Ameri	
**	The state of	Ē	1 ☐ Never Married 2 ☐ Marr	ied 1 Yes 2	™ No					o Rican, etc.)		Black, White	
2 6	dir.	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 2 🛣 No	Specif	y:		Spe	ecify:	White
ling	72 hc	Completed	15. Deceden (Specify only higher			16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	ost of worl	king	16b. Kind o	f Business/Ir	ndustry
9 5	ithin ithin	du	Elementary/Secondary (0-12)	College (1-4	lor 5+)			id)				_	
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	tal H	Be	17. Father's Name (First, Middle,							ne (First, Middle n North		name)	
8	Men Men Marke	ဥ	James Arthur			405 14-10						um Ctata 7	- Codel
Jac Que line	12 sh 12 sh 1 and 1 ie m		19a. Informant's Name/Relations Patricia Shawy		or)		ng Address (Street						b Code)
	T and Health		20a. Method of Disposition	er (Daught						Date		on - City or T	own. State
र्वे :	S S S S S S S S S S S S S S S S S S S		1 Burial 2 □ Cremation		ate		osition (Name of matory or other pla	- 1	<i>6</i> 1	2006			
Regan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel; or Items 23a or 28a-1 show appringry or other traumatic event, the Madical Experiment nature confilled at ance.		4 Donation 5 Other (S		ва		e Nat. C			-2006		more,	MD
~ B	Derm Depa Impo		Dat f	411			2. Name and Addre Hardest 851 Ann	y Fur apoli	ieral Is Ro	Home, ad, Gam	P.A. brills	, MD 2	1054
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the deat ch line.	h. Do not en	ter the mode of dy	ng, such a	as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- br	Innon	2	Labor.	-					Onset and Death
	/Medical		resulting in death)	Que lo (o	r as a conseq	иепсе оі):	,			0 ^	_		
	Examiner		Sergentially list conditions.	chows	suc D	13/	etne p	Non	my	-dr	easl	-	
	D #	Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ras a conseq	uenc of):							
	ecute and -tran:	cam	that initiated events resulting in death) Last	C. Due to (or	r as a conseq	uence of):						-	
0250	Attending Physician: The law requires that the death certificate be executed in death. The death. Cotor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	E	, , , , , , , , , , , , , , , , , , , ,	000 10 (0)	as a conseq	derice ory.							
7	cate the physic the t	dicai		d									
;	OX O	/Me	IF FEMALE:	23c. If yes, outco	ome of pregna	incv					224	Date of deliv	1004
, a	BOX Or Beath certific attending profouse as	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ☐ Feta nt at time of d	I death 3	☐Ectopic pregnand ☐ Other (specify) _	y			230.	Month	Day Year
	that the de ed by the detached	Ş	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow			_ 0 (110) (0)0001// _						
	INVISION OF VITAL MECONDS, F.O. I or Attending Physician: The law requires that the dather death. Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached.	by Physician/Me	Part II. Other significant conditi	ons contributing to dea	th but not res	ulting in the u	ınderlying cause gı	ven in Par	11.	23e. Did	tobacco use	contribute to	the cause of death?
3	w requires been sign should be	a D								1	Yes 2□N	o 3□Pro	bably 4 Unknown
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Ć	The lav	Ĕ								per	opsy formed?	death?	ompletion of cause of
3	VICAL F ician: Th certificate ector, pag	e C	25. Was case referred to medica	1				26 Pla	re of Dea	th (Check only	2 No	1 🗆 Yes	2□ No
5	vaicie s cert	To B	examiner?	Hospital:	patient 2	ER/Outpatie	nt 3 DOA Ot	her		ome 5 Res		Other (Speci	fv)
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	a fun after	ig i	1 Natural 5 Pendi	ng (Month) gation	, Day rear)	Injury		Yes 2	□No				
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	DIVISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical		ng Physician: To the b Examiner: On the bas and manne	sis of examina								
	o the	Me	29b. Signature and title of certific				29c. Licen	se numbe	r		29d. Date si	gned (Month	Day, Year)
	- 5 - 0) ASI	7	mi		DIL	297	7		MA	30	200h
			30-Name and address of person	who completed cause	of death (Iter	n_23a) (Tvpa	Print)	11/			mi		
			Chroken Ches	imti. 301	Ho	12/	Rul	Wen	n B	mà.	WM	. 210	201.
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	Regist	rar	JUN 0	1 2006	then y	13	affin						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Renee Ellen Stewart 2006 June 4:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5645 Knobby Place Waldorf Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days, Year) 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 217-76-3712 49 Yrs. **Director** January 7,1957 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If item 27 is marked other then "netural", or Items 23e or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Waldorf MD Charles 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20601 5645 Knobby Place USA Be Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Motor Vehicle Admin. License Examiner ulth and Mental Hygid 27 Is marked other r treumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary G. Stewart George H. Stewart 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5645 Knobby Place, Waldorf, MD 20601 John Munson/Husband other 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State MD à permit. Page Department of Importent: If any Injury or once. Brinsfield-Echols June 3, 2006 Charlotte Hall * 4 ☐ Donation 5 ☐ Other (Specify) 22BRINSFIELD CHOLS FUNERAL HOME, P.A. 20622 21. Signature of Fuperal Service Licensee 30195 Three Notch Rd. Charlotte Hall.MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Priysician Pancreatic Cancer /Medicat Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attanding Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 🎇 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturai Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident by the 1 6 Could not be determined 3 TSuicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a
To the Funerel C 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Dey, Year) D-28352 June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. P.O. Box 1703 La Plata, MD 20646 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JUN 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 💪 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 ear June 3, **Physician** 2:37A Ethelreda Minerva Swann /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Clinton Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Mar. | 18, 1941 | Wash. D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 65 Director 213-40-7958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Prince George Clinton Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 9501 Badger Ave. USA 20735 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② 100 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter eny injury or other traumatic event, the Medical Exama 1X Never Married 2 Married Specify: Amer. Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Transportation Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera E. Proctor Thomas A. Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 6201 Dower Village La.Mellwood Upper Mari. 19a. Informant's Name/Relationship (Type, Print) Rose B. Swann/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Edgewater, MD. Kalas Crematory 6/6/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Ligense 22. Name and Address of FacilityGeo. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.20745 Mul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OSSTructive Pulmonary **Physician** Chyoni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed buriai-transit Due to (or as a consequence of) Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Cther (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, ate has been sign page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 1 Contifying Physician: To the best of my knowledge death occurred at the time, date and place and due to the dause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1988 15 1. 110 06-03-0 MD 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 SOUTHERN AVE SE, DC 132 MD-121me Bolella 31. Date filed (Month, Day, Year) State JUN 0 5 2006 Registrar

		•	For State Registrar	State of M	1arylan		rtment of F		d Mental	Hygien	7111	6	19173
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Maryland 21215-0036	should nd Me mark matic	2	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route	Number, City	or Town, S	tate, Zip	Code)
æ ∑	Ith ar		MARY A. STAFFOI	RD/WIFE			RIVERDAL						
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Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Signature of Funeral Service/Li	censee / a (11		2. Name and Address 474 LAND		J. B. AD LAN				HOME 20785
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0	w requires been sign should be	eted							-		_	-	
of Vital Records,	6 S CA	Completed	CEREBRAL EI	DEMA					- 248	 Was an autopsy performed 	pi di	ior to cor	psy findings available inpletion of cause of
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₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	ationt 2	ER/Outpatier	nt 3 DOA Ct	her	Death (Checking Home 5 [6 □Othe	r (Snecih	<i>(</i>)
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<u></u>	Attending I r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day (dai)	Infury		Yes 2 No					
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of	Injury - At h		reet, factory, office			ation (Street or Town, St		r or Rura	l Route Number,
۵	O = O =			0									
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 X Certifying (Check only one) 2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examina	owledge, deat ation and/or in	h occurred at the to exestigation, in my	ime, date and p opinion, death o	lace, and due occurred at the	to the cause e time, date a	(s) and mar and place, a	nd due to	ated. the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier	1.0	111		29c. Licen			29d. l	Date signed	(Month,	Day, Year)
)		1	100	500	110		D48	3213		JU	JNE 2	, 20	06
R	(2)	1	30. Name and address of person w	•			•						
			NEELAM ASHAI] 31. Date filed (Month, Day, Year)					HILLS,	MARYL.	AND 20	784		
	St Regist	ate	JUN 0 5 2	006	کر خی	k de	de						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary Serado May 29, 2006 9:30 P. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Waldorf Charles First in Quality Care Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Nov. 2, 1923 Birthplece (State or Foreign
Country) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 XX Pennsylvania 82 Director 579-36-1622 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, If a Medical Examinat must be notified at 1 Yes XXX No Maryland Prince George's Ft. Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 309 Heyse Court 20744 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes = 2\$\times 2\$\times No if Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 12 Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Audit Clerk Federal Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Serado Mary Tedesco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Williams / Sister 708 Buckmaster Lane Ft. Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' permit. Pages Department of Important: If it any injury or c 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Church Cem. June 2, 2006 Clinton, Maryland ✓ S □ Other (Specify) 22. Name and Address of Facility Funeral Service Licenses 21. Signature George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** C Ance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2121 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence & State (Specify) Living Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2XXNo this After this funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 KX atural 5 Pending within 24 hours after usa....
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3520C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Road, Fort waskington us 2 20744 Illiam T. TANKER KY 1001 31. Date filed (Month, Day, Year) State JUN 0 5 2006 Registrar

			For State Registrar	State of Maryl		artment of I		d Mer		ene g. No.2 ()	06	19175
1525	89.		1. Decedent's Name (First, Middle, Last)						Date of Death Month		Year	3. Time of Death
	Physicia /Medic	al	Walter Clevelar		Sr.				ay 2		006	2:36 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town,		eath		4c. County		
	gd		Anne Arundel Medic		rs. last birthday		polis	Hrs o	Oate of Birth	Anne Z		
	Funeral Director			M 2□F 7. Age (III)		Months Days		Min.	(Month, Day, une 18	,1930_	Wash	place (State or Foreign ntry) D.C.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					1	Od. Inside City Limits
	hours after deeth with the Maryland tural', or flems 23a or 28a-f show at Expriner must be nothing at	ō	MD Anne Arur	ndel	Lau	rel						1 ☐ Yes 2 No
	tha 1	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	h with	ai D	4 South Betty St	-		207	724			US	Ą	
	deet ms 2	Funerai		12. Was Decedent Ever i Armed Forces?	n U.S. 13.	. Was Decedent of If Yes, specify Cut	Hispanic Origin oan, Mexican, P	? (Specify	Yes or No-		e - Americk, White,	ean Indian,
9	or its		1 Never Married 2 Married	1 X Yes 2 □ No		1 ☐ Yes 2 ☒ No			,	Specif		
8	72 hours 'natural',	d by	3 Widowed 4 Divorced	Year or Dates: 195		edent's Usual Occu				6b. Kind of B	MITT	
5	na na	iete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	e kind of work done DO NOT use retire	during most of	working		db. Kilid of B	u3111 0 33/111	dustry
21215-0036	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Au	tomobile	mechani	ic		Autom	obile	service
P	Try E	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (F	irst, Middle, M	laiden Surnan	7e)	
/lar	ould ba Mental varked o	ToE	Frank Sweeney				Mabel	l Hol	mes			
Maryland	s 1 and 2 should Heelth and Mer tem 27 is marks other traumatic		19a. Informant's Name/Relationship (Ty			ling Address (Stree						Code)
	s 1 and f Heelth Item 27 other tr		Edna R. Sweeney /		And the second second second	uth Betty		Laur	el, MD	 207. Oc. Location 		Num State
Baltimore,	<u>0</u> 0 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	ramoval from State		osition (Name of ematory or other pla						
Him		,	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			rans Ceme			111111111111111			MD.
Ba	parmit. Departr Imports any inje		Buan	Powell		6512 NW (l Fune: Bowie	ral Ho e, MD.	ne 207	15
3	* \$		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the cause on each line.	eath. Do not er	nter the mode of dy	ing, such as car	rdiac or re	spiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		sepsi	5						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	L	0/-1		1 -			112-68
	LAGHINE	_	Sequentially list conditions,	b. Due to (or as a con	e de	UC 1	0971	100	TIN)		Vievi
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	Pan	creas	Cer	n C	e~		0 0 0	Maries
,	be axecuted sician and buriat-transit	Examiner	that initiated events resulting in death) Last	Oue to (or as a con	sequence of):	Circa						
760,	w - w	cai	(d								
68			IE EENALE.									
Вох	death certifica e attending ph d for usa as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐		□Ectopic pregnan	су			1	te of delive	ery Day Year
.O.	0 0 0	Physician/Med	1 Yes 2 No	4∏Pregn <i>a</i> nt at time 9□ Unknown	of death 5	Other (specify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Duy 10u.
0	that the de led by the a detached i	F	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause g	iven in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?
rds,	50 00	d by							1 🗆 Ye	s 2 🗆 No	3 🗆 Prol	pably 4 Unknown
Record	aw requir is been si 2 should	Completed							24a. Was an	24b.	Were auto	ppsy findings available impletion of cause of
Re	The law cete has page 2	mo;							perform	ed?	death?	2 No
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?					Death (C	heck only one)		
of V	% ≤ 0	2	1 Yes 2 No		2 ER/Outpatie	ent 3L DOA			5 Resider			(y)
n c	Jing P	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury	W	uryat ork? ⊒Yes 2.⊟No		. Oescribe ho	w injury occur	red	
isic	l or Attending after death. Director: After I in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm s				Location (Str	eet and Numi	er or Rur	al Route Number,
Division	after Direct	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	moot, ractory, office	,		City or Town,			,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Exem	rsicien: To the best of my iner: On the basis of exa	knowledge, dea	ath occurred at the investigation, in my	time, date and p	place, and occurred	due to the ca at the time, da	use(s) and m te and place,	anner as s	stated. o the cause(s)
	thin 2, the F	Medical	one) 29b. Signature and title of certifier	and manner stated.			nse number			d. Date signe		
	7 × × 00) Imm	>. (/t/1).	ne	N	1043	16	3	417	79/1	160
R	(2)		30: Name and address of person who c	ompleted dause of death	(Item 23a) (Type 2001	Print)	PKW4	A	MARA	is 1	nD	21401
	Sta		31. Date filed (Month, Day, Year) JUN 0 5 2006	32. Registrar's S	ignature	Ri			, , , , , ,			,
P.S.	Regist	rei	JOH 0 0 2000	MANUAL PROPERTY.	ATTEN	The same of the sa						

			_ FOr	partment of Health and M	-	•	10170							
			Tiografia.	ertificate of Death		g. No. 4000	0 19176							
	Physicia		1. Decedent's Name (First, Middle, Last) John Everett Sadler		2. Date of Death Month May 29,	Day Year	3. Time of Death							
5	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
	_ Admin	<u> </u>	Coastal Hospital at the Lake	Salisbury		Wicomico								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Dave Hours Min	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)							
	Director		233-26-0109 86		October	8,1919 Wes	t Virginia							
	and and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits							
	Maryi f ehc	ţo	MD Wicomico Mardela S	Springs			1 ☐ Yes 2√☐ No							
	r 28a	rec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?							
	th with	Funeral Director	23616 Bluebird Lane	21837		USA								
	eme arm	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	I. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White								
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: Whi	te							
Ö	within 72 hours after death with the Maryland one. Then "naturel", or iteme 23a or 28a-f ehow he Medical Exactarar must be notified at	ed b	15 Decedent's Education 16a Dec	edent's Usual Occupation	11	6b. Kind of Business/li	ndustry							
5	in 72	piet	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ng		,							
212	d with giene	Completed	6 Pou	try Farmer		Poultry								
9	al Hygi d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)								
yla	should be ind Mental marked o umatic eve	2	Raleigh William Sadler	Betty V										
Maryland 21215-0036	C1 00 00	0		iling Address (Street and Number or Rura Worcester Hwy., B			p Code)							
<u>5</u>	tom 27 tom 27 tom 27		Larry Sadler (son) 8903 20a. Method of Disposition 20b. Place of Dis			Oc. Location - City or T	own, State							
ŌE	Pages nent of I int: If It		142 Burial 2 Cremation 3 Chemoval from State		2.2006	Berlin, Md								
Baltimore,	permit. I Departm Importar any injur	1		22. Name and Address of Facility Th										
m	Depa Impo any ir		1 Sect Burtage	108 William St., B	erlin, M	d. 21811								
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac of	or respiratory arres	st,	Approximate Interval Between							
1	Physician		Immediate Cause (Final disease or condition a Metastatic Malign	ant Melanoma			Onset and Death							
	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):											
	ate be executed sysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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x 68	ertifica ling pl	Med	IF FEMALE:											
Вох	death certificate e attending phy id for use as the	by Physician/Medi		B Ectopic pregnancy		23d. Date of deli- Month	very Day Year							
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	that ned by deta	Y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?							
rds	The law requires that the sete has been signed by the page 2 should be detache				1 ☐ Yes	3 3 No 3 □ Pro	bably 4 Unknown							
O O	aw re	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of							
Ä	The I	E O			perform	ed? death?	2 No							
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)								
of \	Physi this c al dire	၉	1 ☐ Yes 2X No Hospital: 1X Inpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		me 5 Resider	nce 6 Other (Spec	ify)							
uo	ding f h. After funer	tion	1 X Natural 5 ☐ Pending (Month, Day Year) Injur		280. Describe nov	willing occurred								
Division of Vital Records,	Attending r death. ector: Alter by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Stre	eet and Number or Ru	ral Route Number,							
ă	s after of Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de and manner stated. Certifying Physician: To the best of my knowledge, de and manner stated.											
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	, Day, Year)							
			CALLEL M	D26278	5-	-30-06								
B	H 2		30. Name and address of person who completed cause of death (Item 23a) (Type David E. Cowall, M.D. 351 Deers Head		isbury, N	<u>1d.</u> 21801								
	Sta Regist		31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	_										
			JUN 0 5 2006											

			For State Registrar	•	partment of Health and ertificate of Death		ene 2006	1917
	Physici	_	Decedent's Name (First, Middle, Last) ELWOOD WILSON ST	EWART		2. Date of Death Month JUNE (Day Year 3. 2006	3. Time of Death 12:25 A M
	/Medio Examir		4a. Facility Name (If not institution, give street and REEDERS MEMORIAL HOME	and number)	4b. City, Town, or Location of Dea		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 🗵 M 2	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Y) JULY 10,		olace (State or Foreign htry) HINGTON, DC
	the Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WASHINGTON	10c. City, Town or	Location BOONSBOR	0	1	0d. Inside City Limits 1 Yes 2 No
art	or 28a	Direc	10e. Street and Number	1	10f. Zip Code		g. Citizen of What Cour	
Stewart	<u> </u>	by Funeral Director	1 Never Married 2 Married 1		21713 3. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2♥ No Specify:	Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Americ Black, White, Specify:	ean Indian, etc.
N. S-	in 72 hours after n natural, or its	Completed b	15. Decedent's Education (Specify only highest grade comp	pleted) 16a. De (Gi	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	rking	Sb. Kind of Business/In	HITE dustry
7	A per per per per per per per per per per	Be Com	Elementary/Secondary (0-12) Co	llege (1-4or 5+) 4 CERT	TIFIED PUBLIC ACCO	UNTANT F me (First, Middle, Ma	EDERAL GOV	ERNMENT
Imood	d 2 should b th and Ment th and Ment 7 is marked traumatice	To Be	HOWARD STEWART 19a. Informant's Name/Relationship (Type, Pr	int) 19b. Ma	ALICE Willing Address (Street and Number or F		City or Town, State, Zip	Code)
	the second		BILL STEWART/SON 20a. Method of Disposition	20b. Place of Dis	SUNDOWN FARMS WA		MARYLAND oc. Location - City or To	20832 own, State
me: E	Daltillor permit. Pages Department of Importent: if its any injury or o		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licensee	SMTTHSBI	JRG CREMATORY 6/0 22. Name and Address of Facility BAST FUNERAL HOME	7606 Old	National I	Pike
Ma			23a. Part . Enter the diseate complication shock, or heart failure. List only one cau Immediate Cause (Final	s that caused the death. Do not se on each line.	enter the mode of dying, such as cardia			Approximate Interval Between Onset and Death
	Physician /Medical Examiner			Coronary Due to (or as a consequence of): Chron:	^	ask		
ا	(OU, te be executed ysicien and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of): 14 P2 7 Due to (or as a consequence of):	ension			
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	G. DOX	by Physician/M	in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
6	quires thet the signed by uid be detact		Part II. Other significant conditions contribut	ng to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to t	
	The law requires to be a second page 2 should	Completed				24a. Was an autopsy performe	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
437	VICEL The sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospits	al: 1 Inpatient 2 ER/Outpa	Others	ath (Check only one)	ce 6 ☐Other (Specia	(v)
	ION OT nding Phys ath. r: After this e funeral dii	ation: To		a. Date of Injury (Month, Day Year) 28b. Time Injur	of 28c. Injury at	28d. Describe how		Y)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28	 Place of Injury - At home, farm, building, etc. (Specify) 	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	ne Hospit 24 hour ne Funer pletely fills	Medical	(Check only 2 Medical Examiner: C	To the best of my knowledge, J. In the basis of examination and/o and manner stated.	eath occurred at the time, date and plan r investigation, in my opinion, death occ	s, and dua to the cau curred at the time, dat	ise(s) and manner 4s a e and place, and due t	o the cause(s)
•	To the virthing To the comp	Σ	29b. Signature and title of certifier The signature and title of cert	han	29c. License number	/	d. Date signed (Month,	Day, Year)
D	DH-3		30. Name and address of person who completed DR. SARID MURCHED		pe, Print) RT, HAGERSTOWN, MD	21740/24	0-420-2666	
	St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 0 5 2006	32. Registrar's Signature	Coede			

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No. 2 1 1 5	101
A.	Physici		1 December 1 Mary (First Middle 1 and	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbo	+
	Funeral Director		1 1 M 2 F Wonths Days Hours Min. (Month, Day, rear)	e (State or Foreign
16	Maryland	tor	10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
25th	th with the 23s or 28s	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/5 W. Dover St. Apt. C 2/60/ 2/5 A	?
36 27	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If Item 27 is marked other then "nature!, or Items 23a or 28a-f show or other traumatic event, the Madical Examiner must be natilised.	by Funer	11. Marital Status 1	
52auc 21215-0036	within 72 hours after ene. then "neture!", or Ite he Medical Examina	Completed t	16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indust 16b. Kind of Business/Indust 16c. Kind of Business/Indust 16	C K
	be filed with stal Hygiene of other the event, the	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	ompany
\mathcal{N}	2 should the and Menter to marked sumatic of a sumatic of	٦	William OSlee Slaughter Cora Mae Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo	e
111 -	permit. Pages 1 and 2 Department of Health a Important: If Item 27 le any injury or other tra ance.		Carolyn Slaughter 107 Blake St. Easton, Maryland 20a. Method of Disposition (Name of Date 1 20c. Location - City or Town.	21601
${}_1^{\mathcal{R}}\mathcal{L}_{\mathcal{L}}^{\mathcal{L}}$ altimore	artment ortant: li injury o		4 Donation 5 Other (Specify) Mid Share Cremation 6/5/06 Cambridge.	MD.
F. Ba	Depa Impo any is		Janelle C. Henry Henry Funeral Home, P.A. 510 washington St. Cambridge MD.	21613
7	Physician		snock, or heart failure. List only one cause on each line.	proximate erval Between nset and Death
8760,	Medical Examiner physician and the prinal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	zars
Division of Vital Records, P.O. Box 6	Hospital or Attending Physician: The law requires that the death certific to hours after death. Funeral Director: After this certificate has been signed by the attending p tely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	y Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ca	ause of death?
al Reco	: The law ro cate has be page 2 shi	Completed	24a. Was an autopsy prior to comple death? 1 □ Yes 2 □ No 1 □ Yes 2 □	etion of cause of
Vita	ysician: The l is certificate ha director, page	To Be	25. Was case referred to medical examiner? 1	
sion of	ttending Phys death. ctor: After this y the funeral di	ation: T	27. Mannay of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	
Divis	oltal or Attenurs after deathurs Ineal Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, Iarm, street, factory, office 28f. Location (Street and Number or Rural Roll City or Town, State)	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	l. cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, D 3 1 3 7 6 F 3 1 7 7	Year)
			Junes Sides MD D31376 5-29 TX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dantes Diles MD 910 Market St Deuten MS 31. Date filed (Month, Day, Year) 32. Regulator's Signature)
14 37 169	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registar's Signature JUN 0 1 2006	24639

Registrar

JUN 0 1 2006

		1	For State Registrar	State of Mar	ryland		rtment tificate				giene Reg. No.	006	19180	
	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death	
	Physicia /Medic	al l	James L.		Seil	bert,				May	30	2006 ounty of Death	8:35 a ^M	
	Examin	er '	4a. Facility Name (If not institution, give		o o le			own, or the name of the name o	ocation of Death	1	40.00		rundel	
	F		Genesis Eldercar 5. Social Security Number 6. Se		(In yrs. las	st birthday)	If Under 1	Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign ntry)	
	Funeral Director			X M 2□ F	76	Yrs.	Months	Days	Hours Min.	Oct. 1	6, 192	29 Vir	ginia	
pu	1000	<u> </u>	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits	
Aaryla	ital Hygiene. id other then "neturel", or Items 23a or 28a-f ehow event, ihe Madical Exbuiline must be notified at	_	MD Anne Ar			hady :							1 ☐ Yes 2 🛣 No	
the		rect	10e. Street and Number			<i>J</i>	10f. Zip 0	Code			10g. Citize	n of What Cou	intry?	
h with		Funeral Director	1245 Hawthorne S	treet			2	2076	4			USA		
r deal		ner	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. \	Was Decede 1 Yes, specif	ent of His Ty Cuban	panic Origin? (S) , Mexican, Puert	pecify Yes or No o Rican, etc.)	D- 14	Race - Ameri Black, White		
UU30 hours after death with the Maryland		by Fu	1 □ Never Married 2 ② Married 1 □ ③ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1952-60						Sį	Specify: White				
Maryland 21215-0036			15. Decedent's Ed	ucation		16a. Decec	dent's Usual	Occupa	tion uring most of wor	tina	16b. Kind	of Business/Ir	ndustry	
Within 72	en "n Madi	Completed	(Specify only highest grad	College (1-4or 5+	.)	life. L	DO NOT use	retired)	aning most or work	king		A 1	1 0	
17 Pg	other th		9			Fire	Fighte		18. Mother's Nan	ne /First Middle			1 County	
and Be ii		Be	17. Father's Name (First, Middle, Last) James L. Seibert	. Sr.						E. Tipp				
Taryla 2 should	f Health and Mer Item 27 is marke other treumatic	ဥ	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address ((Street a			Number, City or Town, State, Zip Code)			
	alth a 27 io r treu		Audrey E. Seiber	t (Wife)					e Street	, Shady	Side	, MD 20	764	
- 0	Depertment of Her Important: If Item eny Injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Dispo netery, crer	sition (Nami matory or oth	e of her place)	Date	20c. Loca	ition - City or T	own, State	
Ĕ ª			4 □ Donation 5 □ Other (Specify)	Woo		d Ceme			2006	Gale	sville,	MD	
	mpor mpor any in		21. Signature of Funeral Service Licen	÷ee	_	22	Name and Harde	estv	Funeral	Home,	P.A.		20765	
	020 d		23a art1. Enter the diseuse, or composhool or heart fail ye. List only of	lications that caused t	the death.	Do not ent	905 (ter the mode	fale:	sville R	or respiratory	lesvi.	lle, M	Approximate	
			shoo or heart fail e. List only of himmediate Cause (Fine	ine cause on each line	9.	MA	aliai	1.au	A lui	unlunc	Ma	0.0	Interval Between nset and Death	
	nysician Medical		Inmediate Cause (Fine disease of condition resulting in death) a. Due to (or as a consequence of):										1-1 years	
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P	sit.	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	t consaque	ince of).								
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	ig phy as the		la estima		_									
Division of Vital Records, P.O. Box	tendir or use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							23	23d. Date of delivery Month Day Year			
О. В	been signed by the attending physician and should be detached for use as the burial-transit	/sici	1 Yes 2 No	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)				ecify)						
Q. \$		P.	Part II. Other significant conditions of	ontributing to death bu	it not result	ting in the u	inderlying ca	use give	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
ds,		d b	Acute ve	ual fai	luve	2				10	Yes 2□	No 3□Pro	obably 4 🕱 Unknown	
COL		jete	Rheumata	oid av	thui	17				24a. Wa	s an	24b. Were au	topsy findings available ompletion of cause of	
a a	ite ha	Completed	septic a	uthvitis						per 1 Yes	opsy formed? 2 No	death?	2□ No	
ital	To the hospital of Atlanding Prysician: The law requires that the beauthorning within 24 hours after death. within 24 hours after death. completely filled bliector: After this centificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	BeC	25. Was case referred to medical examiner?					Lou	26. Place of Dea	ath (Check only	one)			
of V		၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injur			of 28c. Injury at			ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
ouc.		ion	27. Manner of Death 1 Natural 5 Pending investigation						200. Describe					
/isi		fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office						281. Location (Street and Number or Rural Route Number			ral Route Number,		
ă š		Certification;												
3		Medical (stated. to the cause(s)			
1	To th comp	Me	29b. Signature and title of certifier 29c. License number 29c. Lic						number	mber 29d. Da			ite signed (Month, Day, Year)	
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			30. Name and address of person who	Seloudel	eath (Item	23a) (Type	Prinq0	0	Bestga.	te Au	пар	dis, u	006 wa. 21401	
TO	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatu	ure	and I							

			1 - For State RegistrarAmend# 2 . Per I	State of N							ental Hy	/gien Reg. N	200	6 1016
\$	Physici		1. Decedent's Name (First, Middle, La LEON	st)		INSEND					2 Date of De Month		_{ay} 26, 2006	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv		r)			y, Town, or			1231		c. County of Deat	n .
	Funeral Director		373-30-4416	Sex 7. A	4ge (In yrs. 66	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Unde Hours	Min.	8. Date of Bi (Month, Da SEPT.	ay, Year	r) Co	nplace (State or Foreign untry) HINGTON, DC
Dog No.	a-f ehow	tor	Usual Residence of Decedent	GEORGE 'S		ty, Town or Lo		GTON						10d. Inside City Limits 1X Yes 2 □ No
ih th	or 28	Director	10e. Street and Number				10f. 2	ip Code				_	itizen of What Co	untry?
5-0036	A Hault and Marial Hygiene. Hear 27 is marked other than "natural", or items 23s or 28s-1 ehos other traumatic event, the Madical Examinar must be notified at	by Funerai	7713 LOUDON DRIV 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 XYes 2 E If Yes, Give Year or Dates	s?]No Ai	rforce	1 🗆 Yes	2[X No	ispanic O in, Mexica Specify		cify Yes or No Rican, etc.)	0-	-per).	a, etc. BLACK
21215-	then "nat	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-40	r 5+)	16a. Dece (Give life.	kind of t DO NOT	vork done d use retired	<i>during</i> mo f)	st of workin			Kind of Business/	
land 2	th and Mental Hygiene. 7 is marked other then "r traumatic event, the May	To Be Co	17. Father's Name (First, Middle, Last MOSES TOWNSEND			COLLIG	111.04		18. Moth		(First, Middle		n Sumame)	
_ ;	other traumal		19a. Informant's Name/Relationship (•						or Town, State, 2	
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Balt	Department of the programment of the temportant: If its eny injury or of page.		21. Signature of Europe Service Lice	nsee									S FUNERA MARYLAND	
)	hysician and /Medical ivanial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	ETES '	TYPE I	E							Onset and Death
Box 6	e attending p	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	al death 3	□Ectopic □ Other	pregnancy specify)					23d. Date of deli Month	very Day Year
	een signed b	d by Pł	Part II. Dther significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part	I.			_	the cause of death?
- Rec	ete has page 2	Complete									24a. Was auto perfo 1 \(\text{Yes}	opsy ormed?	death?	topsy findings available completion of cause of
/ita	this certificeteral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		e of Death	(Check only	one)		
on of	After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		28b. Time o Injury		28c. Injury Work	401	2	ne 5 Res 28d. Describe		6 ☐ Other (Specury occurred	cify)
Divisi	ifter dea Olrector in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	08 Place of I	njury - At h etc. <i>(Speci</i>	iome, farm, sti fy)					28f. Location (City or To			ral Route Number,
	ne nospital n 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the timon, in my of	ne, date a pinion, de	ath occurre	and due to the	cause(, date ar	s) and manner as nd place, and due	stated. to the cause(s)
)	withii To the comp	¥	29b. Signature and Wile of certifier	ellur	מ		İ	9c. License		8			ate signed (Mont)	
2		ato	30. Name and address of pelson who CRYSTAL YELDE 31. Date filed (Month, Day, Year)	LL M.D. 5		UTHWAY		TLAND,	, MAI	RYLANI	2074	46		
1. 15	Sta Reaist	ate rar	JUN 0 5 2006		. k	has	81							

Ш			1 - State of Ma	aryland / Depa <i>Cei</i>	artment of Heartificate of De			ene g. No. 200	6 19182
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Beulah G. Taltavul	1			2. Date of Death Month 30,		3. Time of Death 5:00P M
	Examir		4a. Facility Name (If not institution, give street and number) 3330 N. Leisure World Blvd. #219		4b. City, Town, or Loc Silver Sprin			4c. County of De Montgomer	
	Funeral Director		214-84-6556 1□M 2□XF 84	e (In yrs. last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth Month, Day, July 22,	9. B 1921 Mar	irthplace (State or Foreign Country) Tyland
	Maryland I ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo Silver Spri					10d. Inside City Limits 1 ☐ Yes 2XXNo
	th with the 23a or 28e	Funeral Director	10e. Street and Number 3330 N. Leisure World Blvd. #219		10f. Zip Code 20906		10	g. Citizen of What (Country?
900	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or iteme 23e or 28e-f show say injury or other traumatic event, I'm Medical Examinar must be notillised at Once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 West Fixes, Give Year or Dates:	lo l	Vas Decedent of Hispai I Yes, specify Cuban, M I □ Yes 2 1 No Si	nic Origin? (Spe lexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh	
Baltimore, Maryland 21215-0036	ad within 72 h rgiene. er than "netu t, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	lent's Usual Occupation kind of work done durin DO NOT use retired) Mother	l g most of workir	ng	6b. Kind of Busines At Home	s/Industry
yland	tould be file Mental Hy Parked oth	To Be	17. Father's Name (First, Middle, Last) James F. Brewer]	Beulah G.	(First, Middle, M Fitzpatri	ck	
ore, Mar	es 1 end 2 sh of Health and f item 27 ie m r other traum		19a. Informant's Name/Relationship (Type, Print) W. Warren Taltavull/Husband 20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State	3330	g Address (Street and I N. Leisure Wor sition (Name of natory or other place)	rld Blvd.	#219 Silv	150,500	D.20906
Baltim	permit. Pag Department Important: I eny injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		atory . Name and Address of 60 Oxon Hill		F. Kalas		
	Physician /Medical		resulting in death)	the death. Do not ente e. ry Hypertensi	er the mode of dying, su				Approximate Interval Between Onset and Death 1 year
8760,	cate be executed by sician and the burial-transit can	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initial devents c.	a consequence of): a consequence of): a consequence of):					
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₾.	w requires that the de been signed by the a should be detached i	Ď	Part II. Other significant conditions contributing to death be Atrial Fibrillation	at not resulting in the un	derlying cause given in	Part I.			to the cause of death?
al Reco		Completed					24a. Was an autopsy performs 1 ☐ Yes 2 L	prior to	utopsy findings available completion of cause of
Division of Vital Records,	Attending Physician: Thir death. ector: After this certificate by the funeral director, par	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injur (Month, Day)		0.0	□ Nursing Hom	Check only one one 5 🕅 Residen 8d. Describe how	ce 6 □Other (Sp	acify)
Divisi	i Diffic	Certification:	3 ⊆ Suicide 6 □ Could not be	ry - At home, farm, stre . (Specify)			8f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Chak o h) (Chak o	examination and/or inv	estigation, in my opinior	n, death occurre	d at the time, dat	e and place, and du	e to the cause(s)
	Towitt	~	29b. Signature and title of certifier Ruld Wenth MD		29c. License nun D42777	mber		1. Date signed (Monay 31, 2006	th, Day, Year)
1	(15)	to.		nce Philip Dr	. Suite 125 0	Olney, MD.	20832		
	Sta Registr		JUN 0 5 2006	r's Signature					

Please Type or Print in Black Indelible Ink Gregory Paul Underwood State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra: Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** GREGORY PAUL. UNDERWOOD 1036 hrs June 2, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 2808 Lime Street Temple Hills Prince George's 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Foreign WASHINGTON Days Hours Director 1 X M 2 55 578-68-4265 03/16/1951 DC. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show e notified at once. Yes 2 X No 28a-f show MT PRINCE GEORGE TEMPLE HILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2808 LIME ST. UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White etc. Yes 2 X No Widowed Divorced If Yes, Give Year Yes 2 X No specify Specify: WHITE. other than "natural", ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 PROVISIONAL MAILER NEWSPAPER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) THOMAS C. UNDERWOOD, JR tem 27 is marked traumatic event, RITA E. CAREW 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA E. UNDERWOOD - MOTHER 5904 MT. EAGLE DR., ALEXANDRIA, VA 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place' 06/06/2006 FALLS CHURCH, VA NATIONAL CREMATORY Donation 5 Other Specify 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON ST., ALEXANDRIA complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** the dise Approximate Interval failure. List only one cause on each Between Onset and /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last Physician/Medical UNPENDED AMENDED Box 68760, JE FEMALE 23c. If yes, outcome of pregnance 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? \$ Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 1 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other₄ Nursing Home 5 Inpatient ER/Outpatient 3 DOA Residence 6 V Other Scene ဥ 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self Natural FOUND Pending Yes 2 V No Jun 2, 2006 1015 hrs 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be determined (Specify) Single Family 2808 Lime Street, Temple Hills, MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and little of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E June 3, 2006 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUN 0 5

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 **Physician** Robert Shellman Witter June 2:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Carroll 4b. City. Town, or Location of Death Examiner Westminster 600 Oneta Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar 19, 1934 Birthplace (State or Foreign
Country) **Funeral** Months Days M 2□F Hours Yrs. Director 214-30-1808 72 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. The Madical Examinar must be notified at Westminster Carroll Director 1 Tyes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 600 Oneta Drive USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or the any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1956— If Yes, Give Year or Dates: 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 22 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David C. Witter Marjorie E. Crabbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Witter, wife 600 Oneta Drive, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2 Cremation 3 Removal from State 06/05/2006 Westminster, MD Meadow Branch Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunature of Funeral Service Lica 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 witer 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Matastatic disease or condition resulting in death) pancractic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consa uente f attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò None 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1 Yes al or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJZ 10+1NA who completed cause of death (Item 23a) (Type, Print) St. Westminster md. 21157 Pa: m.D. 555 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUN 0 2 2006 Registrar

06-03799 Donna Wilson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	•	ate of Death		Reg No 201	06 1918
Physicia Vedical Exami	an/	Decedent's Name (First, Middle, Last) Donna Ellen WILSON			2. Date of Dea Month June 3, 2	Day Year	3. Time of Death 1950 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c County of Deatl	h
Funeral		5 Winter Street Apt 2 5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	Hagerstown If Under 1 Year If Under 1 Year	der 24Hrs. 8. Date of B	Washington irth(MM/DD/YYYY) 9. Bir	rtholace (State or
Director		212-80-6401 1_M 2XF	39	Yrs. Months Days Hou	rs Min	Foreig	
any	ļ	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	or Location	-		10d Inside City Limits
<u> </u>	١	Maryland Washington		erstown			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		10g Citizen of What Cou	intry?
ith the 23a or notifie		5 Winter Street, Apt. 2	Fires in U.S.	21740	ining / Connet. Von an N	USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene ant. If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces?	X No	 Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 		White, etc	ican Indian, Black,
s after ural", o	3	Widowed 4 X Divorced of Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade company)	oleted) 16a [1 Yes 2 X No specify Decedent's Usual Occupation (Give		Specify: W	hite
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0036 within 72 jene rer than "	duc	12 0		none		none	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be C	Donald Lee Jordan			er's Name (First, Middle, etty Mae Ch	•	
and 2 should be fi leath and Mental tem 27 is marked traumatic event.	2	19a. Informant's Name/Relationship (Type, Print) Betty Jordan - mother		. Mailing Address (Street and Nu			
e, MD 1 and 2 shou Health and 1 item 27 is r	1	20a. Method of Disposition	20b. Place of	Winter St., Ap Disposition (Name of cemetery.	Date	20c. Location - City or	
More Pages 1 ent of H nt: If it		1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	i.c	ory or other place) stown Crematory	6-8-06	Hagerstown	n, Maryland
Baltimc permit Page Department Important: injury or otd	1	21. Signature of Funeral Service Licensee	0	22. Name and Address of Facil	ty MINNICH	FUNERAL HOM	E
Physician		23a Part I. Enter the disease, or complications that caused to	he death Do no	415 E. Wilson tenter the mode of dying, such as			. 21740 Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Complications of	f Chronic Alc	oholism	, ,		Between Onset and Death
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ì	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):				
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ffcate be execute g physician and the burial - tran	/Medical	IF FEMALE: 23c. If yes, outcom	e of pregnancy	-		23d. Date of deliver	y
Sox 687 leath certific e attending p		23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at t	ime of death 5	Fetal death 3 Ectop	ic pregnancy	Month [Day Year
Box 68 e death certil the attending ed for use as	Physicia	1 Yes 2 No 9 V Unknown 9 Unknown					
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stare death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed				24a. Was	an 24b. Were au	utopsy findings available
ecor he law te has t	Ja mg				auto perfo	ormed? death?	completion of cause of
Vital Rec ysician: The I his certificate I	Be	25. Was case referred to medical examiner?			(Check only one)		
f Vit Physic er this rral dire	ျ	1 ✓ Yes 2 No Hospital: 1 Inpatier 27. Manner of Death 28a Date of Injur		itpatient 3 DOA Other 1		Residence 6 Other	r. Scene
Vision of or Attending Phefer death Director: After tin by the funeral	tion:	1 Natural 5 Pending (Month, Day,Ye	ar)	1 Yes 2	_	now injury cocarroa	
Division Hospital or Attent 24 hours after death Funeral Directors	Certification:	Suicide Could not be	ury - At home, far	rm, street, factory, office building, e	etc. 28f. Location (or Town,	Street and Number or Ru	ıral Route Number. City
Ospital bours a uneral f	S	4 Homicide determined (Specify)	landar da de la de	Ab			
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	edical	(Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam and manner stated.		-			
£ 3 £ 8	Μe	29b Signature and title of certifier	0 0	29c. License numbe	r	29d. Date signed (Mo.	nth, Day, Year)
		tot Uroni - Tall	leh in	O.C.M.E.		June 5, 2006	
SH-2		 Name and address of person who completed cause of de Patricia Aronica-Pollak MD. Assistant M 	eath (Item 23a) edical Exami	iner 111 Penn Street, B	altimore, MD 2120	01	
S	tate	31. Date filed (Month, Day, Year) 32. Redistrar	s Signature	Angeles .			
Regis	પાસા	3011 3 3 2000 1	as his	William .			

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			1 = For State Registrar	State of Ma		partme <i>ertifica</i>			ind Me	ental Hy	giene Reg. No.	200	6	918
	Planeis		1. Decedent's Name (First, Middle, Las	")						2. Date of De	ath			Time of Death
	Physic /Medi		Edward Perry Web	ber Jr.						Month May 3	31, Day			12:56P ^M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, o	Location of	Death			County of D		12,501
			Holy Cross Hospita	1		Sil	ver S	pring			Mo	ontgom	erv	
	Funeral	1	Social Security Number 6. S		(In yrs. last birthda	y) If Und	er 1 Year	If Under 2		B. Date of Bir	th	9. 8	Birthplace (State or Foreign
	Director		219-34-8486	X M 2□F	67 Yrs	Months	Days	Hours	Min.	(Month, Da	y, Year) 193		Country) ` irgin:	
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	ith to	Dic	10e. Street and Number			10f. Z	ip Code				10g. Citi	zen of What	Country?	
	ath v	rai	11805 College View	Drive			0902				USA			
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at	Funeral Director	11. Marital Status	Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Dec	edent of Hi	spanic Origi n, Mexican.	in? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	14. Race - Ar Black, W		lian,
36	or l	by F	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give			2 💢 No	Specify:				Specific		
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Maryland 21215-0036	d 2 should be filed within 72 ho th and Mental Hygiene. 77 ie marked other than "natur treumatic event, the Maxical		Brenda Webber/daugl		19b. Ma	illing Addres	s (Street a	nd Number	or Rural I	Route Number hersbu	er, City or	Town, State	, Zip Code,)
	feat feat om 2		20a. Method of Disposition		100			Jourt		-				
Ď	it of lifter or o		1 ☐ Burial 2 【Cremation 3 ☐ F	lemoval from State	20b. Place of Dis cemetery, c	rematory or	other place	·	Dat		20c. Loc	cation - City	or Town, St	ate
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Baltimore,	permit. Pages. Department of I Important: If Ite any Injury or of		21. Signature of Funeral Service Licens	40 1	MO1251	22. Name a Joing	nd Addres Home	of Facility Crema	tion	Servi	ce :	P.O. E	30x 78	34 D 21029
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ie cause on each line.	e death. Do not e	inter the mo	de of dying	, such as ca	ardiac or r	espiratory ar	rest,	LASVII	Appro	eximate al Between t and Death
8760,	Medical Examiner by Special Paragraph of the parial-transit the parial	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):								hour	5
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on	ding Ph h. After th funeral	i	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	м	28c. Injury : Work?			l. Describe ho	ow injury	occurred		
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á	2 # # E	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (\$	Specity)					Location (SI City or Town	1, State)			Number,
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	Withii To th	ž	29b. Signature and title of certifier			290	c. License	number		2	9d. Date	signed (Mon	th, Day, Ye	ar)
			> Dalki	with			D0983	4				2, 20		
Oá	>	-	30. Name and address of person who con	npleted cause of death	(Item 23a) (Typo							_, _,		
0			Barry N. Rosenbaum,		0 Farrag		e. Ke	nsinot	ton	MD 203	395			
1.	Sta Registra	te	31. Date filed (Month, Day, Year) JUN 0 5 20	32. Res strar's	Signature	A. w	o, Re	-roming(20119	200				

DHMH 17 Rev 1/2001

INAL (301) 949-4242

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>	lental Hygie Reg.		
			Decedent's Name (First, Middle, Last)		2. Date of Death	21111	3. Time of Death
	Physici		Vincent Elmer Young		June 2	Day Year 2006	1:29 A M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Location of Death		4c. County of Deat	
			Southern Maryland Hospital	Clinton		Prince Ge	enrge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
	Director		577-40-4992	Months Days Hours Min.	(Month, Day, Ye pril 28.	1931 Wash	ington, D.C.
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Li				
	aryla ehov	2	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Ne M	Director	Maryland Prince George's Temple Hil				12 Yes 2 No
	with t	ū	10e. Street and Number	10f. Zip Code		Citizen of What Cor	
	e 23	Funeral	4113 Holly Tree Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20748		ted State	
	Item Iner	Ë	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
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ŏ	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at	ted	15. Decedent's Education 16a Dece	dent's Usual Occupation	16b	. Kind of Business/l	ack ndustry
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Ja	should band Ment	To	Vincent S. Young	Josephi	ne Morris	S	
Maryland 21215-0036	2 sho and leme		19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rura	l Route Number, Cit	y or Town, State, Z	ip Code)
	and 2 ealth n 27				ondale, P	A 19311	
ore	of H of		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, creations.	esition (Name of Direction of Direction (Name of Direction)	ate 20c.	Location - City or 1	own, State
<u>Ĕ</u>	Pages ment of ent: if it ury or o		1 ← Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	edar Hill June	3, 2006	Suitland,	MD
Baltimore,	permit. Page Department of Importent: if eny Injury or once.		21. Signature of Funeral Service Lie price 22	Name and Address of Facility Alexander S. Pope	Funeral H	Homes, P.	Α.
		\dashv	(Color (Color)	538 Marlboro Pike	Forestvi	lle, MD	20747 Approximate
	B		23a. Part 1. Enfer the disease or complications that caused the death. Do not eni shock, or heart sallurs. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
į	Physician /Medical		disease or condition resulting in death)	ascular A	elider	5	
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Š	leath certific attending p	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliv	,
P.O. Box	he at	Physiclan/M		Other (specify)		Month	Day Year
<u>.</u>	res that the de signed by the a be detached t	E.	3 DOTINIOWII				
Division of Vital Records,	The law requires that the death certate has been signed by the attendin page 2 should be detached for use	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to t	
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<u> </u>	icien certif rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
5	Physicien: The la r this certificate has ral director, page 2	<u>٩</u>	I Ainpatient 2 ER/Outpatien		ne 5 Residence		fy)
0	Attending Physicien: r death. ector: After this certifict by the funeral director,	盲	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	jury occurred	
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2	after Direction by	Certification;	4 Homicide determined 200. Flace of injury - At nome, farm, str	sor, ractory, onice	City or Town, Sta	ate)	ar noute ivamber,
	Hospital or 24 hours after Funerel Dir letely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	(s) and manner as s	tated
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edlcal	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	restigation, in my opinion, death occurre	d at the time, date a	nd place, and due t	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	29c. License number	29d. C	ate signed (Month,	Day, Year)
)	000		AN T	D46478	6-	2-06	
01	IO/IV		30. Name and address of person who completed cause of death (Item 23a) (Type,				
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	Sta		31. Date filed (Month, Day, Year) Registrar's Signature	ø:			
	Registra	ar .	JUN 0 6 2006 Keeper A April	a)			

			1 - For State Registrar	State of	Maryland		artmen rtificate			and M		jiene eg. No.	006	19188
•	Physici	an	Decedent's Name (First, Middle, La.	st)					<u>4</u> ;		2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	cal	Beulah W. Zai 4a. Facility Name (If not institution, giv		nber)		4b. City.	Town, or	Location o	of Death	May 30		6 unty of Death	9:25 p M
	Exami	iei	3335 Lowman Lane						Brida				Carro1	
	Funeral		5. Social Security Number 6. S	ex	7. Age (In yrs. Ia 78		If Under Months		If Under	24 Hrs. Min.	8. Date of Birth			nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	U W ZUAL	70	Yrs.					06/20/	1927		minster, MD
	yland		10a. State 10b. County			, Town or Lo								10d. Inside City Limits
	e Mar	Director	MD Carrol	1	Ur	nion E	ridge	2						1 ☐ Yes 2 🙀 No
	with th	Dire	10e. Street and Number				10f. Zip				1		of What Cou	untry?
	ns 234	Funeral	3335 Lowman Lane		dent Ever in U.S	3 13		.791	snanic Orio	nin? (Sne	cify Yes or No.	USA	Race - Amer	ican Indian
9	n 72 hours after death with the Maryland *natural', or Items 23a or 28e-f show edital Estatratuchus be notified at	Fun	1 Never Married Married	Armed For	ces? 2 ½ ∄No					, Puerto F	cify Yes or No- Rican, etc.)		Black, White	, etc.
003	ural', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2		Specify:			Spe	ecity: Whi	ite
15-(Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usua kind of wor DO NOT us	k done d	turina most	of working	ng	16b. Kind o	f Business/Ir	ndustry
212	d within piene. r than	отр	Elementary/Secondary (0-12)	College (1-	4or 5+)		utive			v		Blac	k & De	ecker
pu	be filed Ital Hygi od other event, L	Bec	17. Father's Name (First, Middle, Last, Frank Witte						18. Mothe	r's Name	(First, Middle, I	Maiden Sun	name)	30,102
yla	should be nd Mental marked o	Tol												
Maryland 21215-0036	nd 2 shouth and 27 is m		19a. Informant's Name/Relationship (Richard L. Zander	* .	ısband						n Bridg			
	Hea Hea the		20a. Method of Disposition	-	20b. Pla	ace of Dispo	sition (Nam	ne of	T.	D	ate		on - City or T	
E O	Pages nent of nnt: If it ury or o		1 ☑Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Ever	green	"Mem."	Gar	dens	06/0	3/06	Finks	burg,	MD
Baltimore,	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licer	1900							ts Fune: Westmins			Chapel, PA 1157
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death.	. Do not ent	er the mode	of dying	such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	CUCA	UC	ue	M	2		A	·- <u>.</u>		Once and Death
	Examiner			Due to (o	or as a conseque	ence of):		*						
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to lo	or as a conseque	ence of):					*****			
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be executed hysician and the burial-transit	aiE		Oue to (o	or as a conseque	ence or):								
687	ate Ph	edicai		. d										
Вох	death certifics e attending ph d for use as t	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnan		Ectopic pre	agnancy				23d.	Date of deliv	ery
O. B	the dea y the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		int at time of dea		Other (spe		-				Month	Day Year
۵.	that ed b deta		Part II. Other significant conditions of	ontributing to dea	ath but not resul	Iting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use o	ontribute to t	the cause of death?
of Vital Records,	law requires as been sign 2 should be	ed by									1 □ Y€	s 2 🗆 No	3 Prol	bably 4 Hinknown
900	law re as bee 2 sho	Completed									24a. Was au	24	b. Were auto	opsy lindings available
Ä	The la	Com									perform	ned?	death?	2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only one	-		
of	Phys or this oral dii); To	1 Yes 2 No	1 ∐ fn 28a. Date of	f Injury 2	R/Outpatien 28b. Time of		A Bc. Injury Work	4 🗆 Nur		ne 5 Reside 8d. Describe ho			fy)
ion	Attending F r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		i, Day Year)	Injury	М		? ′es 2□N	10				
Division	after deatl after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined	286. Place 0	of Injury - At hong, etc. (Specify)	ne, larm, str	eet, factory,	office		2	8f. Location (Str City or Town	reet and Nu , State)	mber or Rura	al Route Number,
	Hospitel of the sale of Funerel Ditely filled in		29a. Certifier 1 Certifying Ph	voicion. To the h	neat of my know	dodgo dost				1-1				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On the bas	sis of examination	on and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time, da	ite and plac	manner as s e, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	A			_	License			29	d. Date sig	ned (Manth,	Day, Year)
)	WIN		- Januo (Mel	LID			35	39	8		6	0110	0
	Malo		30. Name and address of person who Flavio Knuter	M.D.	555	S. Ce	nter	5	t. n	Vest	minst	er N	ND Z	1157
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1	2006 32. Re	Grar's Signatu	Jr.	book							

06-03996

Please Type or Print in Black Indelible Ink

inda Marie Branc	1	- For State	e of Marylan		artment of		and	Menta	al Hyg		eg No.	200	610	718
Physician Medical Examine	1	Registrar 1. Decedent's Name (First, Middle,Li				D		- la		Date of Dea Month June 10, 2	nth Dav	Year	3 Time of D	210
Medical Examine		I. inda 4a Facility Name (if not institution, g	rive street and numb	arie ber)	4	b. City, Tow Woodla		cation of I		Julie 10, A	4c. Cou	nty of Deat	h	
Funeral	4	6315 Monika Place # 71 5. Social Security Number 6.		Age (In yrs. I	ast birthday)	If Under 1		If Under :	Min		rth (MM/DD/Y		rthplace (State	
Director	-	213-90-0305 1	M 2XF	41	Yrs.		Dayo			04 1	0 65	Co	ountry) MI)
Maryland 28a-f show any d at once.		10a State 10b. County MD NA			Town or Location								10d. Inside 0	•
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 6315 Monika P	lage An	+ 712		10f. Zip Co		1207		1	10g Citizen of	What Cou	•	-
h with the ems 23a c	_ L	11. Marital Status 1 X Never Married 2 Marrie	12. Was Deced	dent Ever in U		Decedent of	of Hispa	anic Origin		ify Yes or No	D- 14. R		rican Indian, Bl	ack.
after deat al". or ite iner musi	by Fun	3 Widowed 4 Divorc	1 Yes ed If Yes, Give Year or Dates:	2 X No	1	Yes 2 X	No	specify:			Spec	ıy.	Black	
2 hour	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12th grade	College (1-4 2yrs		`	's Usual Ocost of workin	g life D	OO NOT us			16b. Kind o		/Industry	
21215-0036 Build be filed within 7 Mental Hygiene marked other than e event, the Medica	S P	17. Father's Name (First, Middle, La Howard Denni							,	irst, Middle, canch	Maiden Surna	ame)		
2 B S E S	2	19a Informant's Name/Relationship Williams Betty William	(ype, Print)								mber, City or		e, Zip Code) 21201	
ore, MD 2 shot of Health and 1 If item 27 is 1		20a Method of Disposition 1 X Burial 2 Cremation	-	n State	Place of Disposi crematory or oth	tion (Name er place)	of ceme	etery,	D	ate	20c. Locati	on - City o	r Town, State	_
Baltimore, permit Pages I an Department of He Important: If tier injury or other tr	-	4 Donation 5 Other Spec 21. Signature of Funeral Service Lice		Ki	ng Mem	ame and Ad	Idress o	f Facility		7/06	Rand	alls	town,	Md
ம் திதித்தி Physician	-	23a. Part I Enter the disease, or co	Eclino mplications that cau	ised the ath		rch E 00 Wa me mode of d	ba: dying, su	sh A uch as car	Ve /	Balt espiratory ar	imore	, Md	212. Approxima	te Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	a Atherosc1			ular d	iseas	æ					Between C	
and the same of th	١	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c				-							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c		·						 	· · · · · ·		
0, e be executed ysician and burial - transit	edical Ex		dX_ AMENDED	//00	07 M	056.6	r /00	/oc mm					-	
760, cate be ex physician the burial		IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, ou	tcome of preg				_				e of deliver		
Box 68760, the death certificate be executed by the attending physician are other for use as the burial transit	siciar	past 12 months?		nt at time of de		al death ner (Specify	3 [_	Ectopic	pregnanc	y	Mont	n	Day	Year
P.O. res that the signed by t	by Phy	Part II. Other significant condition	s contributing to	death but not r	esulting in the u	nderlying ca	ause giv	ren in Part	.t	17			the cause of contact the cause	
cords law requi	Completed									24a. Was auto perfo	psy ormed?		utopsy findings completion of o	
/ital Rec	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		To	of Death (Control	Nursing F	, pan	Residence	6 🗸 Othe	er: Scene	
n of Vading Phy	ion: To	27. Manner of Death 1 X Natural 5 Pending		f Injury Day,Year)	28b. Time of I		, ,	at Work?		3d. Describe	how injury oc	curred		
Divisior pital or Attend ours after death eral Director:	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	28e. Place	of Injury - At h	nome, farm, stree	et, factory, o	ffice bui	ilding, etc.	28	or Town,		umber or R	ural Route Nur	mber, City
D To the Hospital within 24 hours To the Funeral	Medical Ce	29a. Certifier 1 Certifying Phys	sician: To the best ner:On the basis of	examination a										
To wit To com	Mec	29b. Signature and title of certifier	and manner sta	0			icense	number			29d. Date		onth, Day, Year)
		30. Name and address of person will Margarita Koroll MD		,		enn Stree			MD 24	201				
, Sta		Margarita Korell MD. 31. Date filed (Month) Pary Year) 9	Assistant Medi	strar's Signat		enn Stree	ei, Bai	unnore,	IVID 21	201				
Registi	rar	2011 1 0	2000	CHUM	15 186									

		1 - For State Registrar	State of Marylan		tment of H			giene Neg. No.2	06	19	190
Physi	ician	Decedent's Name (First, Middle, Last,		/			2. Date of Dea Month JUNE		Year	3. Time of	
	dical		Belton		45 Ob T	1			2006	3:10	E W
Exam	niner	4a. Fedity Name (If not institution, give)	redical Cent			r Location of Deal Tows	on	4c. Coun	ty of Death Balt	imore	
Funera Directo		5. Social Security Number 6. Sec 264-56-4511	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year 1937		lace (State of	or Foreign
pu 🛾		Usual Residence of Decedent 10a, State 10b, County	10c Cit	y, Town or Loca	ition		/			0d. Inside Ci	ib. Limits
death with the Maryland oms 23a or 28a-f ehow r must be notitied at	٥	MD BALTI				11110			'	1 🗍 Yes	
r 28a-	Director	10e. Street and Number	110/02	7-0	10f. Zip Code	2017	· -	10g. Citizen of	What Coun		
th with	aiD	1.300 Airlie U	NAY APPI.		21	239		U.	5.A.		
er dea	Funerai		12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	as Decedent of H res, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra Bl	ace - Americ ack, While,		
rs atte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	Tyes, Give Year or Dates: NAV	5.	Yes 20 No	Specify:		Spec	ity: RL	ACK	
tiled within 72 hours atter tiled within 72 hours atter Hygiene. ther then "neturel", or Ite ont, the Medical Exertine		15. Decedent's Edu (Specify only highest grad	cation	16a. Decede	nt's Usual Occup	ation		16b. Kind of I	Business/Inc	dustry	
athin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use retired	during most of wo	irking			٠	
iled w Hygier ther th		17. Father's Name (First, Middle, Last)	NA		_A BOR	18 Mother's Na	me (First, Middle,	TNT Maiden Suma		USIR	9.
ld be ld be ked o	To Be	JOSEPH BRITI					MAY B		,		
in Innore, Interview A 12.13-0030 init. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan artment of Health and Mental Hygiene. ortant: If Item 27 ie marked other then "neturel", or Items 23a or 28a-f ehow injury or other treumatic event, the Medical Examination matter mentals.	-	19a. Informant's Name/Relationship (Ty				and Number or R	u <i>ral R</i> oute Num <i>b</i> e	r, City or Town	n, State, Zip		
and 2 ealth m 27 i		MARY Belton		1300	AIRLIE	WAY	Be Ito	. pus	2123	9	
ges 1 If of H		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	lace of Disposit emetery, crema	ion (Name of tory or other plac	(e) 6	Date	20c. Location	- City or To	wn, State	
permit. Pages Department of Important: If it	_	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		y View	Cremato	SS of Facility	10/06	Barte	, MS		
permit. Departi	Suca	V Jaulyn . 5	tella	Pr	FULSTEL	TA FUNE	RAI HEM BAlte	MO 2	1234		
ķ.		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death	n. Do not enter	the mode of dyin	g, such as cardia	c or respiratory ari	est,		Approximate Interval Bet	ween
Physicia	_	Immediate Cause (Final disease or condition resulting in death)	SEPSIS							Onset and I	Jeath
/ /Medica Examine		Tooling in dealing	PNEUMONIA	uence of):							
	le le	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o								
reate be executed physician and sthe burial-transit	E	resulting in death) Last	Due to (or as a consequ	reuce of):							
oo / ou iticate be e g physician as the buria	edicai		d								
Cert din se	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal		atania ara sa sa s			23d. D	ate ol delive	гу	
ecords, F.O. Bo law requires that the death as been signed by the atten 2 should be detached for ur	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		ctopic pregnancy Other <i>(specify)</i>			M	lonth	Day h	Year
hat the set by t		9 Unknown Part II. Dther significant conditions con	ntributing to death but not resi	ulting in the und	erlying cause gry	en in Part I	23e. Did to	bacco use cor	ntribute to th	e cause of d	leath?
w requires to been signed should be	d by	NON-SMALL CELL			, g calco g		1	es 2 No		ably 4 □U	
aw req	Completed						24a. Was a		. Were autor	osy findings	available
1 9 4 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	l mox						autop: perfor 1 ☐ Yes		death?	npletion of ca	ause ol
VICAL ician: T certificat ector, pi	Be	25. Was case referred to medical examiner?	to actual S. A.				ath (Check only or	Θ)			
Physi This c	- To	1 ☐ Yes 2 No	lospital: 1 Alphatient 2 2	ER/Outpatient 28b. Time of	3 DOA Oth	er: 4 Nursing I	dome 5 Resid	ence 6 Ot	ther (Specify	')	
ording th: Atter	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injun Work	k?`` Yes 2 □ No	254. 2555.125 11	ow with the			
r Attending or death.	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	t, lactory, office		281. Location (S City or Tow	treet and Num	ber or Rura	Route Num.	ber,
DIVISION OF VICE To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: Atten this certitic completely tilled in by the tuneral director.	O	COn Contilion And Contilion Di									
24 hos	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and magner stated.	wiedge, death o tion and/or inve	stigation, in my o	ne, date and place pinion, death occi	e, and due to the c urred al the time, d	ause(s) and mate and place	nanner as sta , and due to	ated. the cause(s)
To the To the To the Comple	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date sign	ed (Month, L	Day, Year)	
l.		1	Som		D 378	254		6 -	7-0	6	
4	-	30. Name and address of person who co				ICCs ::	ADV4 5:	, dec			
Spile Park	State	31. Date filed (Month, Day, Year)	D., 7601 OSL 32. Registrar's Signa		TAE ION	vaun, M	HKYLHND	2120	4		
	strar	111N 1 0 20	nc A	10 1							

Physic	ian_	Amend Item 8 1 - State Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of D Month			3. Time of Deat
/Medi		Samuel Bryant						June	8	2006	12 45 8
Examir	ner	4a. Facility Name (If not institution, give s	_				Location of Dea	th	4c	. County of Death	1
		5. Social Security Number 6. Sex	Bultimore	In yrs. last birthda		1 Year	If Under 24 Hr	S. 8 Date of Bi	4/1	5/1923	pplace (State or Fore
Funeral Director			IM 2□F	83 Yrs.	Months	Days	Hours Mir	(Month, D	ay, Year)) 2.2	intry) Unk
pu 🔉		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or	Location			*			10d Inside City Li-
faryla sho	ō	MD		Baltimo							10d. Inside City Liπ 1/2 Yes 2 □
ith the Marylar or 28a-f show	rect	10e. Street and Number		Darcinc	10f. Zip	Code			10a: Cit	izen of What Cou	
	Funeral Director	2095 Rock Rose Ave	nue				1211				unk
after death w	ner	11. Marital Status unk	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Deced	dent of Hi	spanic Origin? (Specify Yes or N rto Rican, etc.)	0-	14. Race - Amer	
or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	unk	1 Yes 2		Specify:	no moan, etc.)		Black, White	
CILID-0030 filed within 72 hours after Hygiene. Hydrene "natural", or fle sit, tre Modical Examilia	d by	3 Widowed 4 Divorced	Year or Dates:	16- D-						Bla	
in 72	olete	15. Decedent's Educ (Specify only highest grade	completed)	(Gi	cedent's Usua ive kind of wor a. DO NOT us	rk done d se retired	ation furing most of wo)	orking	16b. K	ind of Business/Ir	ndustry
d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	_	Constr						unk
Ind ZIZI3-0	Be C	17. Father's Name (First, Middle, Last)		,	0011001			me (First, Middle	e, Maiden	Sumame)	<u> </u>
IMATYIATICI Z. I.Z. d.2 should be filled within th and Mental Hygiene. ?? Is marked other than traumatic event, I. e. M.	To		12-1-1		unk						unk
OCE, INGLYIC ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Typ	oe, Print)	-	ailing Address	(Street a	and Number or F	lural Route Numb	ber, City o	or Town, State, Zi	p Code)
C = 04 F		Artie Shaw/other		unk	annition (Man			Data			
DallImore, bermit. Pages 1 ar Department of Hes mportant: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dis cemetery, c	rematory or o	ne or ther place	9)	Date	20c. Lo	ocation - City or T	own, State
Dallimor permit. Pages Department of P Important: If ite any injury or o once.		21. Signature of Funeral Jervice License	le / hm	-	22. Name and State	d Addres Anat	s of Facility	rd 655 V	V. Ba	ıltimore	Street
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused th	e death. Do not e	enter the mode	e of dying	g, such as cardia	c or respiratory a	arrest,		Approximate
Physician		Immediate Cause (Final	e cause on each line.	54.1	0						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	Pheun	1001	Cu				10 days
Examiner		Sequentially list conditions h	Acu	te Renai	Fail	ure	-				10 days
P #	iner	Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):							1
ecute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a o	consequence of):						-	
rou, te be execul ysician and e burial-trar	calE		Due 10 (0) as a 1	orisaquence or).							
ficate physis the		d									
Attending Physician: The law requires that the death certificate be executed redeath. r death. ector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of		-					23d. Date of deliv	erv
	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tin		3 □Ectopic pre 5 □ Other <i>(sp</i> e					Month	Day Year
that the de ed by the detached	hys	9 🗍 Unknown	9□ Unknown								
Invision of vital necolds, r.C. for Attending Physician: The law requires that the dath. Director: After this certificate has been signed by the fine tuneral director, page 2 should be detached.	by F	Part II. Other significent conditions con		not resulting in the	underlying ca	ause give	n in Part I.				he cause of death?
w requir been si should	ted	Obstructive Uro	Puthy					1 🗆	Yes 2[□No 3□ Prot	bably 4 Minkno
law law las be as be	Completed							24a. Was	DSV	prior to co	opsy findings availa
The The cate for page	Cor							1 Yes	ormed? 2⊈ No	death? 1 ☐ Yes	2⊠ No
VII.c	Be	25. Was case referred to medical examiner?	ospital:			Otho		ath Check onl			
Phys rathis	. To	1 ☐ Yes 2 ☑ No ☐ ☐	1 Inpatient	2 ER/Outpat 28b. Time		A Othe Bc. Injury	· La rearrang	Home 5 Resi		6 Other (Special	(y)
ding th.	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) Injury		Work	? 'es 2 □ No	200. 0630106	HOW III III	y occurred	
Atten r deal sctor	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm,	street, factory,			28f. Location (Street an	d Number or Rura	al Route Number,
s affe	Sert	4 Homicide	building, etc. ((Specify)				City or To	wn, State,)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of e er: On the basis of ea and manner state	camination and/or	ath occurred a investigation,	at the time in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License	number		29d. Dat	e signed (Month,	Day, Year)
⊢ s ⊢ ō		Arab um	DO		1 8	260	- 006		_		
		30. Name and address of person who con		th (Item 23a) (Tvn	e. Print)		Balti		00:1	e 8,2	006
	1 1										

			1 - For State Registrar	State of I	Marylar		artment of H		Mental Hy	giene 2	106	19193
	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		John Blume						June 5	, 2006		12:35 p ^M
	Examir	er	4e. Facility Name (If not institution, g.	ve street and number	er)	10.6	4b. City, Town, or	Location of Death	0.0	4c. Count	y of Deeth	
			5. Social Security Number 6.	Sex 7.	And the was	last birthday)	If Under 1 Year	If Under 24 Hrs.	21210	44	0.514	
	Funeral Director		unk	1⊠M 2□F	57	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, De June 10	1948	9. Birthp Cour	place (State or Foreign htry) MD
			Usual Residence of Decedent						P 4110 10	7 10		TID
	how		10a. State 10b. County			ty, Town or Lo	cation				1	0d. Inside City Limits
	ith the Marylar or 28a-f show	cto	MD		Bal	timore						1√2 Yes 2 □ No
	be filed within 72 hours after death with the Maryland lat Hygiene. ud other than "natural", or Items 23e or 28e-f show event, it a Medical Examinar must be notified at	al Director	10e. Street and Number 11 W. 20th Street				10f. Zip Code 21218			10g. Citizen of USA	What Coun	ntry?
	after death w	Funeral	11. Marital Status unk	12. Was Decede Armed Force	nt Ever in U s?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No		ce - Americ	
98	or It	J.	1 Never Married 2 Married	1 ☐ Yes 2[If Yes, Give	XNo		☐Yes 2☐No	Specify:	, , , , , , , , ,			
21215-0036	72 hours natural',	d by	3 Widowed 4 Divorced	Year or Date	s:						w.Whit	
-5-	n 72	Completed	15. Decedent's l (Specify only highest g	ducation rade completed)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	luring most of world	king	16b. Kind of B	usiness/Inc	dustry
12	withi ene. then	E C	Elementary/Secondary (0-12) unk	College (1-4d	unk	1,110.	001101 436164164)		lisabled	n	one	
	filed Hygi ther		17. Father's Name (First, Middle, Las	t)	unik	<u> </u>	unk	18. Mother's Nam	-		one	unk
lan		To Be					dine				,	unk
C. Waryland	s 1 and 2 should be filed within thealth and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the M	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	nd Number or Rui	ral Route Numb	er City or Town	State Zin	Code)
O.C.ME	D € 2 5		O.C.M.E				nn Street				olato, Ep	0000)
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from Sta	te (Place of Disportant	sition (Name of natory or other place	3)	Date	20c. Location	- City or To	wn, State
Baltii	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Lice		1	S	Name and Addres	omy Boar	d 655 W	. Balti	more	Street
			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	nplications that caus	ed the deal		altimore, or the mode of dying			rrest.	-	Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	a. 100	onseq 1	Juence of	anh inem	nl s	hofan	tin.	7	Interval Between Onset and Death
Box 68760,	ate be executed sysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a consequ	Juence of):	Vites)				
68	tifical ng phy as th											
P.O. Box	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	I death 3 🗌	Ectopic pregnancy Other (specify)				te of deliver	ry Day Year
	uires that n signed b	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the un	derlying cause give	n in Part I.		obacco use cont		e cause of death?
100	w require been si should I	lete		-deli	1/				24a. Was	an 24h	Wore autor	osy findings available
Re	The lav	Completed		07000					autop	rmed/!	prior to com death? 1 🔲 Yes ::	npletion of cause of
ita	ysician: T is certifical director, p	Be	25. Was case referred to medical					26. Place of Deat				20110
>	nysic nis ce direc	ToE	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatient	3 DOA Other		- 41		er (Specify	•)
Division of Vital Records,	Mtending Phy death. ctor: After thi y the funeral o		27. Van, er of Death atural 5 Pending Accident investigation	n 1	jury Day Year)	28b. Time of Injury	28c. înjury Work' M 1 🗆 Y	at 7		now injury occur		,
Divis	ital or Att rs after de ral Directo led in by t	Certification;	3 Suicide 6 Could not 4 Homicide determined	building,	etc. (Specif	" N	et, factory, office		City or Tow			
	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by	ledical	one)	hysician: To the be- miner: On the basis and manner	or examina	wledge, death tion and/or inv	estigation, in my opi	inion, death occur	and due to the ored at the time, or	cause(s) and ma date and place.	inner as sta and due to	ated. the cause(s)
	To To	Σ	29b. Signature and title of eartifier	Im	th,	MD.	29c. License	number	9	29d. Date signe	Month. D	Dey, Year)
			30. Na and address of person who	completed cause of	death (Item	n 23a) (Туре, F	Print)	14	ml	2003	9	
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signa		1 41	4.1.	ye y	100	1	
4	Registr	_	JUN 1 9 2				eve					

State of Maryland / Department of Health and Mental Hygiene 1 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2006 **Physician** June 13, 4:30 Рм Tilmon Bolling Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Cromwell Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 19, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**/25**₩ 2□ F Maryland 213-12-4377 85 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 end 2 should be filed within 72 hours atter death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!", or items 23a or 28s-f ehow any injury or other treumatic event, it a Medical Examinar must be notified at Middle River 1 ☐ Yes 217 10 Director Maryland Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7202 Greenbank Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1XXYes 2 No 1942— If Yes, Give Year or Dates: 1945 Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2XXXVo Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ella Jane Herring Rols Walter Bolling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Naomi Bolling (Wife) 7202 Greenbank Road, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. June 17,2006 Baltimore, Maryland 4 Domation 5 Other (Specify) Sommure Meral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enfer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure—ent only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 1 Yes 2 No 2 1 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the bast of my knowledge. Seth occurred at the time, date and place, and due to the cause(s) and memor as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and-title of certifier 29d. Date signed (Month, Day, Year) Olu all 10059855 June 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Locky Raven Blvd Battimore 560 31. Date filed (Month, Day, Year) a. Registrar's Signature State Registrar 2006

Holy Cross Hospital Silve Funeral Director 5. Social Security Number 0.5 Sex 1 Day 1 Director O75-18-0553 1 D M 2 M F 83 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 11620 Kemp Mill Road 2 Margard 1 D	ing ° 0902	2. Date of Death Month June 8. Date of Birth (Month, Day, November 2	Day Year 15 2006 4c. County of Death Montgomer Year) 9. Birth; County of Death Montgomer New 19. Birth; County of New 1	3. Time of Death 2:38 AM Py Place (State or Foreign nty) York 10d. Inside City Limits
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town	r Spring Par If Under 24 Hrs. Par Hours Min. Par Min. Pa	8. Date of Birth (Month, Day, November	4c. County of Death Montgomer Year) 26, 1922 New	y place (State or Foreign ntry) York
Holy Cross Hospital Funeral Director Holy Cross Hospital Silve Silve 6. Sex 1 Age (In yrs. last birthday) 1 M 2 M F 83 Yrs. Silve Months Day	r Spring Par If Under 24 Hrs. Par Hours Min. Par Min. Pa		Montgomer Year) 26, 1922 New	place (State or Foreign ntry) York
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 1 Usual Residence of Decedent	ing e 0902		9. Birth 26, 1922 New	place (State or Foreign ntry) York
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Usual Residence of Decedent	ing ° 0902			
Maryland Montgomery Silver Spr 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spr 10b. Street and Number 10f. Zip Code 11620 Kemp Mill Road 20 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 No	0902	10		10d. Inside City Limits
Maryland Montgomery Silver Spr Silver Spr	0902	10		1 ☐ Yes 21 No
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The second secon			Og. Citizen of What Cou	-
Armed Forces? If Yes, specify C Armed Forces? If Yes, specify C Armed Forces? If Yes, specify C	Juhan Mayican Puerto	ecify Yes or No-	14. Race - Ameri	
W 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Rican, etc.)	Black, White,	etc.
Midowed 4 MiDivorced HYes, Give 1 ☐ Yes 2 ☑ N	No Specify:		Specify: W	nite
15, Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work dor	cupation ne during most of works tired)	ing	16b. Kind of Business/In	dustry
Elementary/Secondary (0-12) College (1-4or 5+) 5+ Paralegal	tired)		Law Firm	
N POLITICAL TO THE FAIL ALL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF THE FAIL STATE OF	18. Mother's Name	(First, Middle, A		
Kirkor Kehaghackian	Marie H	Baghdad1	ian	
The state of the s	eet and Number or Rura	al Route Number,	. City or Town, State, Zip	Code)
David A. Bhore / Son 12907 Travil	ah Road, P	otomac,	Maryland 20	0854
20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Method of Disposition (Name of cemetary, crematory or other place)	place) June	e 18.	20c. Location - City or To	own, State
E d	um, Inc 200)6	Bethesda, M	
20a. Method of Disposition 1 Burial 2 X Cramation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 4 M01305 22. Name and Adr. Robert A. I 7557 Wiscon	dress of Facility Pumphrey Funet nsin Avenue, I	ral Home/B Bethesda,	Sethesda-Chevy Maryland 2081	Chase, Inc. 4–3501
23a. Part1. Chter the disease, or complications that caused the death. Do not enter the mode of c shock, or heart failure. List only one cause on each line.	dying, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition Severe Sepsis				Oriset and Death
/Medical resulting in death) Due to (or as a consequence of):				
Sequentially list conditions Pneumon1a				
cause. Enter Underlying Cause (Disease or injury				
Tary, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
re be be be be be be be be be be be be be				
	ancy		23d. Date of deliv	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			Month	Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause	•		bacco use contribute to t	
Dementia, Hypertension, Congestive Heart Fa	illure	1 ∐ Ye	es 2 XNo 3 ☐ Prol	bably 4 Unknown
Atrial Fibrillation		24a. Was autops	sy prior to co	opsy findings available empletion of cause of
Com Com		perform		2 🗆 No
25. Was case referred to medical examiner? 1	26. Place of Death			
To so the solution of the solu	4 Nursing Ho		ence 6 Other (Speci	(y)
C	njury at Work? 1 Yes 2 No			
Dementia, Hypertension, Congestive Heart Fa Atrial Fibrillation 25. Was case referred to medical examiner? 1	ice	28f. Location (St City or Town	treet and Number or Run n, State)	al Route Number,
The state of the s	e time, date and place, ny opinion, death occurr	and due to the cared at the time, da	ause(s) and manner as s late and place, and due t	stated, o the cause(s)
1 = 1 = 29b. Signature and title of certifier 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ense number	2	9d. Date signed (Month,	
by Chronicock and	D63579		June 15, 2	006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tayag, MD 1500 Forest Glen Road, Sil	ver Spring	, Maryla	ınd 20910	
State Registrar State JUN 1 9 2006 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:40 M arr /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner SALTIMURE PITAL 8. Date of Birth (Month, Day, Tan 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 72-0840 Months Hours 50 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio 10d. Inside other treumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent Everin U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Blac 1 ☐ Yes 2 ☐ No Specify f Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during lile. DO_NOT_use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene important: if item 27 is marked other than "n any injury or other treumatic event, the Meating. Elementa Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ther's Name (First, Middle, Maiden Surname) Brown 2017 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Nam Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State 120/06 4 □ Donation 5 □ Other (Specify) 21. Signature of Furley Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardio vasev lar atherosclerotic **Physician** unknown /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, oulcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No rmed2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient ဥ 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how intury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Examiner or Attending Physicisn: The law requires that the death certificate be executed physician and the burial-transit Records, P.O. Box 68760, igned by the attending be detached for use as After this certificate ivision of Vital completely filled in by the funeral director death. Director: within 24 hours after To the Funerel Direct Hospitel

28a-f show

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or items 23a

"natural"

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

h

31. Date filed (Month, Day, Year) 2006

MILK MID

29b. Signature and titte of certifier



30. Name and a dress of person to completed cause of death (Item 23a) (Type, Print)

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated.

29c. License number

D47353

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19197

		I- For State Certificate of Death		Reg. No.	
Physicia edical Examir	n/	1. Decedent's Name (First, Middle,Last) DIANE MARIE BROWN	2. Date of De Month June 13,	Day Year	3. Time of Death 1748 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 9906 Canvashack Way Damascus	eath	4c. County of D Montgome	
		9906 Canvasback Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs 8 Date of B	irth (MM/DD/YYYY) 9	
Funeral Director		S. Obcidi Occarry Names	Mi-		oreign ALASKA
	}	Usual Residence of Decedent	1007.	0, 1, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,	
any	ı	10a. State 10b. County 10c. City, Town or Location		-	10d Inside City Limits
*	5	MD MONTGOMERTY DAMASCUS			1 X Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number 10f. Zip Code		10g Citizen of What	Country?
th the Maryland 23a or 28a-f sho notified at once.		9902 CANVASBACK WAY 20872		USA	
th wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 14. Never Married 2 Married Armed Forces? 15. Was Decedent of Hispanic Origin? 16. If Yes, specify Cuban, Mexican, Pue		Io- 14. Race - A White, e	merican Indian, Black, tc.
er dea		1 Yes 2 X No 3 Widowed 4 XDivorced If Yes, Give Year 1 Yes 2 X XNo specify:		Specify:	WHITE
hours after "natural", Examiner	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Busin	ess/Industry
5 72 ho in "na cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	retired)		
5-0036 led within 72 Hygiene. other than '	μč	12TH SECRETARY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Last)	ama (Eirst Middle	T'ARGET'	CORPORATION
215-00 be filed wit ntal Hygien rked other ent, the Ma	2	17. Tatlel 3 Halle (1 list, Middle, Eddy	,	LICE BOL	T.TNG
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other thatie event, the Med	To B	19e Informant's Name/Relationship (Type, Print) Barbara Lemnoff/sister 19b. Mailing Address (Street and Number			
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is market other than "natural", or items 23a or 28a-f shorr traumatic event, the Medical Examiner must be notified at once	İ	BARBARA L. HOFF / SISTER 10214 OAKTON TERM			, VA 22124
nore, MD ages I and 2 sh ent of Health an et: If item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) APPLICATION OF DISPOSITION (Name of cemetery, crematory or other place)	Date	20c. Location - Cr	
		4 Donation 5 Other Specify:	5/19/06		VILLE, MD
Baltimo permit Pag Department Important: injury or ot		21. Signature of Funeral Service Licenses 22. Name and Address of Facility 14600 LIBERTY I			HOME 21207
Physician		2a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory a	rrest, shock, or heart	Approximate Interval
/Medical		Tailure. List only one cause on each line. Imne late Cause (Final disease a. Chronic Narcotism			Between Onset and Death
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ال المحمد	L.	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
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Division tal or Attendii rs after death ral Director: A	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			or Rural Route Number, City
Divisi pital or At ours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town	, State)	
Hospi 24 hou Fune stely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	and due to the ca	use(s) and manner as	s started
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, da		
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		June 14, 200	(Month, Day, Year)
		4000		34110 14, 200	
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
S	tate	31 Date filed (Month, Day Year) 32, Redistrar's Signature			
Regis		JUN 1 7 2006 Bloom & Street			

	_	1	1 - State Registrar Amend #9,11,12&20a-c Per	nd / Department of FH 6837^{j fi}991 29			g. No UU	3, Time of Death
Phys		n	1. Decedent's Name (First, Middle, Last) Earl Cavey			Month	lat 200	
	edica mine		4a. Fecility Name (If not institution, give street and number) Good Samaritan Hospi	tal Bal	or Location of Death		4c. County of De	ath
Funer Direct			5. Social Security Number 6. Sex 7. Age (In yrs. 212–14–0359 1. M 2 F 84	last birthday) If Under 1 Yes Yrs. Months Day		8. Date of Birth (Month, Day, Aug 10	1921 M a	irthplace (State or Foreign Country) cryland unk
Aaryland f show			D. 1	ity, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th the N or 28a-		Funeral Director	MD Ball 10e. Street and Number	10f. Zip Code	9	10	g. Citizen of What	Country?
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ING 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. or thems 23a or 28a-f show event. It a Madical Evanthar Interior		þ	Armed Forces?	1 Yes 2 1	uban, Mexican, Puerti	Rican, etc.)	Black, Wi	
21215-0036 ad within 72 hours at giene. or than "natural", or		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work do life. DO NOT use ret	ne during most of wor lired)	king	6b. Kind of Busine	
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Maryland of 2 should be file lith and Mental Hy 27 Is marked oth		To Be		unk				unk
			19a Informant's Name/Relationship (Type, Print) Good Samaritan Hospital	19b. Mailing Address (Stre 5601 Loch Ra	ven Blvd.	Baltimor	e MD 2123	9
Baltimore, oermit. Pages 1 an Department of Heal Important: If item 2			1 Arrial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other parrison Forest	Vet. 7/1	4/2006	Oc. Location - City Owings Mi	11s,MD
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n of ng Physiter this	funeral dire	9	1 Ves 2 No Pospilal 1 No patient 2 To Mannay of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)		Other: 4 Nursing h		nce 6 Other (S w injury occurred	pecify)
or Atten or Atten or Atten or Atten or Atten	d in by the	Certification;	2 Could not be	home, farm, street, factory, off		28f. Location (St. City or Town	reet and Number of , State)	Rural Route Number,
Hospital 24 hours a Funeral	etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the nation and/or investigation, in r	ne time, date and place my opinion, death occu	e, and due to the caurred at the time, do	ause(s) and manner ate and place, and	as stated. due to the cause(s)
To the within 2 To the	сошр	Me	29b. Signature and title of certifier J. Mukherjee MB	ChB 29c. Lic	ES 000		od. Date signed (M	onth, Day, Year)
			30. Name and address of person who completed cause of death (Ite INDRANI MUKHERTEE 560)	em 23a) (Type Print) LOCH RAVEN A	BOULEVAR	D, BALT	1 more	, mo
Re	Sta gistr		31. Date filed (Month, Day, Year) JUN 1 9 2006 32. Gegistrar's Sign	natura specie				

Earl Cavey

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County o	Physician /Medical	1. Decedent's Name (First, Middle, Carole Cavill	Last)				2. Date of Dea Month JUNE	Day	2006	3. Time of Deat
214-30-5240 Total Residence of December Total Residence To		ST AGNES H	OSPITAL		BALT	IMORE			nty of Death	
The State 100 County 100		214-30-5240			Months Dave		8. Date of Birth (Month, Day June 09	7, Year) 1932	9. Birthpl Coun	try)
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17. Faller's Name (First, Middle, Last) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code)	23a or 21		2					_	of What Coun	try?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2006 11:44 AM 16, Kenneth Brantley /Medical Campbell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 18, 1950 Birthplace (State or Foreign Country) **Funeral** 1∏ M 2□ F 219 58 6305 55 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Rockfleet Road Unit 103 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates: 1968-74 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Communications permit. Pages 1 end 2 should be lik Depertment of Heelth and Mental Hy Important: If item 27 is marked oth any liny or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herbert Brantley Campbell Mary Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Joy Campbell wife 400 Rockfleet Road Unit 103 Lutherville, Md 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 6/21/2006 Garrison Forest, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun val Sprvice Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1 Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAMINZ INFINCTION **Physician** /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien end the burial-transit The law requires that the death certificate be executed Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Year 5 Other (specify) signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown certificete has been s irector, pege 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? After this certification funeral director Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No rector: 2 Accident 6 ☐ Could not be 3 🗌 Suicide within 24 hours after de To the Funerel Direct completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the eauce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month. Day, Year) State JUN 19 2006 Registrar

Baltimore,

Box 68760,

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Records, P.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene ? 1 For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:45 pm 14, 2006 DARE E. CREAMER Tune /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Baltmore HOSPITAI Good NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/15/1957 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 49 1 ☐ M 2 🔀 F 239-94-2429 N. CAROLINA Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits or 28a-f ahow the Medical Exempler must be notified at MD N/A BALTIMORE CITY 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5220 YORK ROAD, 21212 APT. 3P USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: BLACK Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Colfege (1-4or 5+) ASSEMBLY LINE WORKER FURNITURE FACTORY 11TH and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADA FORTUNE EDDIE CREAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Itam 27 is y or other tre LACHELLA CREAMER/DAUGHTER 503 DIXIE ST., LEXINGTON, NC 27292 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 YBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. LEXINGTON CITY CEM. 6/23/06 LEXINGTON, NC 4 ☐Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 23a. Pan exter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Fdisease or condition resulting in death) mediate Cause (Finaf **Physician** Unq /Medical Due to (or as a consequence of): **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed use as the buriaf-transit resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Certification: To 2 ER/Outpatient 3 DOA funeral (27. Manner of Beath 1 Natural 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation injury nours after death.

neral Diractor: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the e 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 6-14-06 60539 MI 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Loch Raven Blud, Baltimore, MA 5601 MI R · Heade liau 31. Date fled (Month, Day, Year) 32. Registrar's Signature State Registrar low & Sparke

lease Type or Print in Black Indelible ink. E	nsure All Copies Are Legible.	
State of Maryland / Department of Hea	alth and Mental Hygiene 🛛 🗍 💍	19202
Certificate of De		
	O Date of Death	2 Time of Dooth

1. Decedent's Name (First, Middle, Last) **Physician** CHARLES M. COOK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street, and number) Examiner ISALTIMOLO If Under 1 Year | If Under 24 Hrs. N/A AGNES Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F Yrs. 214-50-9568 56 07/07/1949 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b County 28a-f ehow the Medical Exeminer must be notified at MD N/ABALTIMORE CITY XIXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 902 N. EDEN STREET 21205 238 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 【 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or iteme Black, White, etc. filed within 72 hours after Never Married 2 Married Maryland 21215-0036 Specify BLACK 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced "naturei", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) OWINGS CORNING Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE WORKER 12TH GLASS COMPANY other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event QDCB. PAUL M. COOK DORIS BRICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IRENE J. COOK / SISTER 902 N. EDEN ST., BALTIMORE, MD 21205 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State LORRAINE PARK CEM 6/20/06 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTYHEIGHTS AVE, BALTIMORE, MD onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final dise or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Completed by Physician/Medical igned by the attending be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ENCEPHALOPATILY 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. efter death 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUN 1 7 2006



un Ohn who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

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une 12,2006

			For State Registrar	State of M	laryland /		rtment tificate			and Me	_	giene	006	19:	203
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	/Media	cal	4a. Facility Name (If not institution				4h City T	Town or I	Location o		Tune	15	200 ounty of Dea		a м
	Examir	ier •	Anne Arundel Medic				Annapo		COOLIGITO	o Dodin			e Arunda		
	Funeral		5. Social Security Number		ge (in yrs. last	- 1	If Under 1	1 Year Days	If Under 2	24 Hrs. 8	Date of Birt (Month, Day	h v. Year)	9. Bin	thplace (State	or Foreign
	Director		190-22-2540 Usual Residence of Decedent	1 X M 2 ☐ F	76	Yrs.				0	2/17/1	930		PA	
	show		10a. State 10b. County	у	10c. City, To	own or Lo	cation				· · · · · · · · · · · · · · · · · · ·			10d. Inside C	City Limits
	a-fsh	ctor	MD Anne A	Arundel	Annap	olis								1 XYes	s 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Extra in artical territifical and once.	Funeral Director	10e. Street and Number 1071 Park Circ	cle Drive			10f. Zip (10g. Citize	on of What Co USA	ountry?	
	r deat	ner	11. Marital Status	12. Was Decedent Armed Forces		13. V	Vas Decede Yes, speci	ent of His	panic Orig	gin? (Specif	y Yes or No-	. 14	Race - Ame		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorce	If YAS GIVE	No		□Yes 2		Specify:				pecify:	White	
21215-0036	2 hour		15. Decede	nt's Education	1 10	6a. Deced	lent's Usual	Occupat	tion			16b. Kind	f of Business		
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Ž	should ind Men a marke umatic	ř	19a. Informant's Name/Relation			19b. Mailin	g Address					r, City or	Town, State, 2	Zip Code)	
	and 2 salth al n 27 is		Betty Demboski	/ Wife									MD 21		
Baltimore,	of He of He ff item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State			sition (Name natory or oth			Date		20c. Loca	ition - City or	Town, State	
ij	Pages tment of I tant; If it		`4 Donation 5 □ Other (Specify)	Meadow				1	6/19/			idge, I	MD	
Bal	permit. Departr Importa any inja		21. Signature of Funeral Service		1378	Gar 72	Name and L. Ka Wash	Address Luffier Lingto	of Facility n Funet n Blw	ral Hon d, Elko	ne at M nicoe, N	1P, IN 1D 210	75		
	Physician // Medical Examiner supplies on the private of the priva	cai Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ine. A consequent a consequent a consequent	e of): ce orj:	rativ	e d	i's ea	SE				Interval Be Onset and	tween Death
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Vital	ding Phyaician: The h. After this certificate h. funeral director, page	Be	25. Was case referred to medica examiner?							of Death (C	Check only or	ne)			
of	Physi this c	To T	1 ☐ Yes 2 No 27, Manner of Death	Hospital: 1 Inpati		Outpatient		All market	4 🗀 Nur		5 Resid		Other (Spec	cify)	
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Division	or Attandi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could 4 Homicide deter	I not be 28e. Place of In	jury - At home, tc. (Specify)	, farm, stre	et, factory,	office		28f	Location (S City or Tow	treet and I n, State)	Number or Ru	ıral Route Nurr	n <i>ber,</i>
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	7		1 04	~~~·	MD			02	919	3		June	_ 16,	2006	
	10		30. Name and address of person Stephen Killia	who completed cause of h MD · 3169	Brave	a) (Type, F	Print)	1 : 2	Edge	water	MD	210	37		
	Sta Registi	-	31. Date filed (Month, Day, Year, JUN 1	9 2006 32. A gist	Brave Brave rar's Signature	A	rede		7						

		•	State of Maryland / Department of Health and M 1- State Registrer Certificate of Death	lental Hygie	4000	19201
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia /Medic		Frank J. DiPietro	June	15 2006	3:30 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deal	h
			Selbourne House of Dorsey Hall Ellicott City		Howa	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign nuntry)
	Director		579-12-2513 88 Yrs. Usual Residence of Decedent	03-17-	1918	_PA
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e-1-e	ţċ	MD Howard Ellicott City			1 ☐ Yes 2 🙀 No
	or 28	S.	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
	ath w	20	5320 Dorsey Hall Dr. Apt. 401 21042		U.S.A	
	items items	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	irs aft	by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: Wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural" or itema 23a or 28a-f ehow ha Madical Examinar must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	16	b. Kind of Business	
215	thin 7	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)			
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ž	d Med d Med mark	၉	10a Informani's Name/Relationship (Type Print) 19h Mailing Address (Street and Number or Rura	ine Gol	ity or Town State	Zin Code)
<u>B</u>	nd 2 s Ith an 27 io		Bette DiPietro (wife) 5320 Dorsey Hall Dr	Apt.	401	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 33a or 28a-1 show amy injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or	Town, State
Ë	Page nent o nt: iff		1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 6-17			lle MD
Baltimore,	rmit. porta y inju	Ī	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wit	zke Fun	eral Ho	mes, Inc.
<u> </u>	89889		The lelle the tank 5555 Twin Knolls	Rd., Co	lumbia	MD 21045
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.		,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) Cowgeofise Heart Faile Due to (or as a consequence of):	u		years
	/Medical Examiner		Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
à	uted d ansit	Examiner	Cause (Disease or injury			
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9	entific ling p	Mec	IF FEMALE:	7		
Вох	death certific e attending p id for use as	lan/	23b. Was decedent pregnant in the past 12 months? Street		23d. Date of del	ivery Day Year
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	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only (Ch	and due to the caus	e(s) and manner as	stated.
	To the H within 24 To the F complete	Medi	one) and manner stated. 29b. Signature and title of contract 29c. License number		Date signed (Mont	` '
\	Twit or no	-		1.1		., Juj, rear)
	44		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	10, 20	
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	Sta		31. Date filed (Month, Day, Year) JUN 1 9 2006			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jaw ZUDE 8:40 AM Owar 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Certer Medical Saltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 29 Days Hours 220-24-486 APRIL 24 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits nt of Heelih and Mental Hygiane.
If item 27 ie marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No PARKUIlle MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 U.S.A. RD 2416 E JOPPA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Heelth and Mental Hygiane. int: If Item 27 Ie marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced ARMY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTO CORP. + Fender BODY 12+4 NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELGERT. Helen PRThur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAXON BAlte M CINDY 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition J-Burial 2 □ Cremation 3 □ Removal from State Cem 19/06 permit. Page Depertment of Important: If eny injury or once. PARKWOOD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL HOME, TAUL STELLA FUR. 7527 horfor RS. 23a. P vt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Periphera lascu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 20 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one, Hospital: 1 patient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Street, 21201 Grasso Grecie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 19 Registrar

			1 - For State Registrar	State of Mary		artment of rtificate			iene 2006	19206
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, L JOSEPH 4a. Facility Name (If not institution, gi	DOUGHE ve street and number) Ge	nesis		n, or Location of De	2. Date of Death Month 5 - 3	Day Year 1 - 200 4c. County of Death	3. Time of Death 2:30 A M
	Funeral Director		5. Social Security Number 6. 215-28-9197 Usual Residence of Decedent		yrs. last birthday) Yrs.	If Under 1 Ye Months Da			Year) (Cor	iplace (State or Foreign intry) Land
	the Maryland r 28a-f show notified at	rector	10a. State 10b. County MD Baltimo 10e. Street and Number		c. City, Town or Lo Randall		θ	10	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
121215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-1 show shy hours or other traumatic event. The Madical Examinar must be inclified at once.	Completed by Funeral Director	9109 Liberty Ro. 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's Elementary/Secondary (0-12) UNK	12. Was Decedent Ever Armed Forces? 1	UNK	dent's Usual Ockind of work do.	of Hispanic Origin? uban, Mexican, Pus No Specify: cupation ne during most of wired)	orking UNK	USA 14. Race - Amer Black, White Specify: White Specific	, etc. Lte Industry UNK
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Division of V	ding Phys h. After this tuneral di	Certification: To B	examiner? 1 Yes 2 Manner ath 1 Manner ath 1 Mural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		28c. In W	ork? Yes 2 No		ce 6 Other (Specific injury occurred	y)
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	Sta Re gistr		31. Date filed (Morth, Day, Year)	22. Registrar's Si	gnature	ests.	ity Koa	u, kandi	UK STOWN,	MD21133

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			Registrar Amend #19		Ana	Bd G856 ^C	entitisate of	Death			Reg. No.			
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ding F		0	27. Manner of Death 1 Natural 5 ☐ Pendir	ng (M	te of Injury on <i>th, Day</i>	Year) 28b. Time Injury	W	uryal ork?]Yes 2.∐i		. Describe h	now injury	occurred		
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C W C O			29b. Signature and title of certifie	·			29c. Licer	nse number	2	1	29d. Date	signed (Mor	nth, Day, Year)	
			30. Name and address of person	who completed a	Juse of do	ath (Item 22a) (Time	Print)	5750			1/18	100		
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	State		31. Date tiled (Month, Day, Year)	32	Registra	's Signature	best	1 /				1011/	The second	UUI
Reg	istra	r	JUN 1 9	2006	A MILAS	1 15 M		~						

		1 - For State Registrar	State of Marylan	-	artment of tificate of			iene 200	6 19203
Physicia		1. Decedent's Name (First, Middle, Last) MARGARET DOWN	NS				2. Date of Death Month		3. Time of Death 6:00A M
/Medic Examin		4a. Facility Name (If not institution, give since \$1807 HAMLIN AVE	treet and number)		BALTIM		Y	4c. County of De	
Funeral Director		5. Social Security Number 6. Sex 212-46-0708	7. Age (In yrs. 59	/ast birthday) Yrs.	If Under 1 Year Months Days			Year)	irthplace (State or Foreign Country)
the Maryland	ctor	10a. State 10b. County MD N/A	10c. City	y, Town or Lo	cation IMORE C	:ITY			10d. Inside City Limits Y☐ Yes 2 ☐ No
3s or 28	i Director	10e. Street and Number 5807 HAMLIN AV	'ENUE		10f. Zip Code 212	15	10	Og. Citizen of What C	Country?
be filed within 72 hours after death with the Maryland half Hygiane. Hygiane, Hygiane, Hygiane, Hygiane, Hygiane, Hygiane, Half Hygiane, H	l by Funerai	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		·
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i and 2 should leath and Men marks marks her traumatic		19a. Informant's Name/Relationship (Type BARBARA MCLEOD	/ DAUGHTER	5807	_		E, BALTI	City or Town, State,	D 21215
permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any Injury or other traugues.		20a. Method of Disposition **Maurial 2	emoval from State	emetery, crem IG MEM	natory or other pla I PARK	6/2	1/06 E		E CO., MD
Depe Impo any l		21. Signature of Ineral Service License	98 Maist	46		ERTY HE	IGHTS AV	E, BALT	OME 21207 IMORE, MD
Physician per executed physician physician and physician and physician and the prital-transit physician ph	dicai Examiner	23a. Fact Enter the decase, or complice shock, or, heart failure. List only one immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence to (or as a consequence)	uence of):	DM Q	In 11	/	Primary	Approximate Interval Between Onset and Death
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To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	') 			City or Town,		
To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by	Medicai	(Check only one) 29b. Signature and title of certifier	ician: To the best of my knower: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my	ime, date and place opinion, death occu se number	irred at the time, dat	use(s) and manner a te and place, and du d. Date signed (Mon	e to the cause(s)
n		30 Name and address of person who con	M, D .	23a) (Type. F	m L	19611	J	une, 15,	2006
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			1 – For State Registrar	State of Maryla	•	artment of F			ene 20	06 19209
			Decedent's Name (First, Middle, Last	")				2. Date of Death	1	3. Time of Death
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Baltimore,	# 된 원 분 .		21. Signature of Funeral Service License			rematory		5/06 <u>E</u>	Baltimo	ore, Md
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Вох	eath certific attending pl	an/	23b. Was decedent pregnant	23c. tf yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	,			of detivery
	e dea he at sed fo	Physician/M	in the past 12 months? 1 🗆 Yes 2 🕅 No	4☐Pregnant at time of		Other (specify)			Mont	h Day Year
P.0	thet the de ned by the a	Ph	9 Unknown			. 4. 4. 5.		On- Dida-b		
	8 20 0	ò	Part II. Other significant conditions co	•	•	, ,			_	bute to the cause of death?
9	w require been si should b	eted	Wastie Ston	NOS1 (10.10	20110	T TODADIY T TOTIK TOWN
Sec.	elaw hast ge 2 s	Completed						24a. Was an autopsy perform	pri	ere autopsy findings available or to completion of cause of ath?
<u>e</u>						****				Yes 2 No
Ζij	Physician: this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:		at 30 pos Oth		ath Check only one		
o	Phys this ral di	: To	1 ☐ Yes 2 No 27. Manner of Death	1 Unpatient 2 28a. Date of tnjury	2 ER/Outpatier 28b. Time o	IL SEL BOX	4 Nursing	Home 5 Resider		
O	ttending death. tor: After the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Wor	k? Yes 2∐No	255. 2555.155	w many occurred	-
Division of Vital Records,	If or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - A						or Rural Route Number,
ò	al or after	Certification;	4 Homicide	building, etc. (Sp.	ecify)			City or Town,	State)	
	To the Hospital or Attivition 24 hours after de To the Funeral Directic completely filled in by the state of the the the the the the the the the the		29a. Certifier 12 Certifying Phy	sician: To the best of my	knowledge, deat	n occurred at the tir	ne, date and plac	e, and due to the ca	use(s) and mann	ner as stated.
	in 24 in 24 in 24 in 6 in 9	edicai	one)	iner: On the basis of exam and manner stated.	imation and/or in	vestigation, in my c	pinion, death occ			` '
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	13-		29c. Licens	e number	29	d. Date signed ((Month, Day, Year)
			122		MAC) n(2757		June	14, 2006
	17		30. Name and address of person who c	ompleted cause of death (^	110		
	[]		31. Date filed (Month, Day, Year)	32. Registrates Si		Kens A	ve R	altimore	mD	21229
4	Sta Registi		JUN 1 9 2006	Clary D.	The state of the s					

Ford, Rosa

			-	State of Mar	vland /	Depa	rtment of H	lealth a	and Me	ntal Hv	aiene	209.2.0.	
		4	1 = For State Registrar		,		tificate of				Rag. No	71116	19210
	Dhysisi	F-3 7	1. Decedent's Name (First, Middle,	Last)					2	Date of De	ath Da	y Year	3. Time of Death
	Physicia /Medic	_	Patricia Ann F							June 1	<u> </u>	2006	12:00 P.M
	Examin	er	4a. Facility Name (If not institution,		0		4b. City, Town, o	_	of Death			County of Death	
-	Funeral	1000	3701 North Poin 5. Social Security Number	6. Sex 7. Age	(In yrs. last b	birthday)	Dundal If Under 1 Year	If Under 2		Date of Bird (Month, Da	th	9 Birtho	lace (State or Foreign
	Director		212-46-3203	1□ M 2□ F 60	0	Yrs.	Months Days	Hours	Min. J1	une 10	,194	46 Maryl	**
	and and		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, To	wn or Lo	cation					1	0d. Inside City Limits
	Maryi	tor	Maryland Baltime	ore	Balti	more							1 ☐ Yes 2 🟋No
	th the	by Funeral Director	10e. Street and Number		Durer	MOT C	10f. Zip Code				10g. Cit	izen of What Cour	ntry?
	ath wi	ral	3701 North Poi			1.0	2122		1.0/0		USA		
	ter de	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo		13. V	Was Decedent of H f Yes, specify Cubi	an, Mexican	gin? (Specii n, Puerto Ric	y Yes or No can, etc.)	-	14. Race - Americ Black, White,	
21215-0036	72 hours after death with the Maryland Instural; or Items 23s or 28s-f show disal Evarither must be multified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	I∏Yes 2∏XNo	Specify:				Specify: Whi	ite
2-0	72 hc	Completed	15. Decedent's (Specify only highest		16	a. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during most	t of working		16b. K	ind of Business/Ind	dustry
121	within ene. than	dmo	Elementary/Secondary (0-12)	Coltege (1-4or 5+))		emaker	a)				Own Ho	ome
1d 2	filed Hygi other	Be Co	17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name (/	First, Middle,	Maiden	Surname)	
/lar	weld be Menta arked atic ev	To B	Abner Baird, S	r.	_			E1:	izabe	th Pog	gie		
Maryland	2 sho and Is ma		19a. Informant's Name/Relationshi	p (Type, Print) Husband								or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or Items 23s or 28a-f show any injury or other treumatic event, Ita Madical Examination in Lating in 2016s.		Ken Ferguson 20a. Method of Disposition	naspand	20b. Place	of Dispos	sition (Name of		Dat Dat			ocation - City or To	
MO.	Pages ent of nt: If It		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Spi				natory or other place n Mem. Ga		6/21/	2006	Marr	iottsvil	le, MD
Baltimore,	permit. I Departm Importei any inju	1	21. Signatur of Funeral Service L		/	22	. Name and Addre	ss of Facility	ySter]	ling A	sht	n Schwab	Witzke
8	89 2 2 2	100	Ma	Mell		116	neral Ho 30 Edmon	ldson_	Avenu	e; Cat	ons	ville, M	
Ь			23a. Part1. Enter the disease, of c shock, or heart failure. List o Immediate Cause (Final	omplications that caused the caused to the cause on each line	ne death. D				_				Approximate Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	a Due to (or as a	CHK		AL II	YPH	KC	T10,	\sim	-	
B	Examiner			CORO	NA	RY	AR-	ER	У	DIS	FA	58	
	21V =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	e of):			1				
	sician and Sician sit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):							
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99	leath certificat attending phy I for use as th		IF FEMALE:								Ī		
Box	death certifica e attending ph od for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal dea		Ectopic pregnancy	У				23d. Date of delive Month	ory Day Year
0	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 Ж Unknown	4 □ Pregnant at ti 9 □ Unknown	me or death	3	Other (specify) _						
Δ.	The law requires that the ste has been signed by the bage 2 should be detached.	by Pr	Part II. Other significant condition	s contributing to death but	not resulting	g in the ur	nderlying cause giv	en in Part I.		23e. Did t	obacco i	use contribute to th	ne cause of death?
Records,	v require been sig should b									10	Yes 2	□ No 3 □ Prob	ably 4 Munknown
ecc	e law r has be je 2 sh	ompleted								24a. Was autor		24b. Were auto prior to con death?	psy findings available mpletion of cause of
al H		0								1 ☐ Yes	2 No		2 No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 □ No	Hospital: 1 ☐ Inpatient	t 2□ER/0	Outpatien	t 3 DOA Ott			Check only o		6 □Other (Specifi	v)
n of	ding Phy h. After thi funeral c	n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury		Time of Injury				d. Describe I			
Siol	Attending in death. ector: After by the fune	catle	2 Accident investigations of Could not	ation			M 1 🗆	Yes 2 □ I			0	411	
Division	l or Attend after death Director: ,	ertification:	4 ☐ Homicide determin		y - At nome, (Specify)	farm, str	eet, factory, office		281	City or Tox		nd Number or Rura a)	I Houte Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in b	O		Physician: To the best of									
	To the Ho within 24 I	ledical	one)	xeminer: On the basis of e		and/or inv			ith occurred				
	To T To T	Σ	29b. Signature and title of certifier	n leen	M	0	29c. Licens	se number	362		29d. Da	te signed (Month,	Day, Year)
	0		30. Name and address of person w	the completed cause of dea	ath (Item 23s	a) (Type	Print)				2	17-7 7 TOC	
	3		FRANCESCO	G RASSO	MO)	6569	N. (CUAI	WES	9	ST TUC	USON
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1	ribe						
σ.	Regist	air	UN 1 9	2006 Jane	, 15.	60	we.						

06-04009 Joseph Griffin

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Time of Death Month Day June 11, 2006 Medical Examiner 1012 hrs Griffin Joseph Lee 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min Director 09 49 03 NC 1 X M 2 Country) 216-48-4526 Usual Residence of Decedent any 10a State 10h County 10c. City, Town or Location IOd Inside City Limits "natural", or items 23a or 28a-f show | | Examiner must be notified at once. 1 X Yes 2 No Baltimore NA MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3910 Boarman Ave 21215 U.S.A. Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1X Yes If Yes, Give Year Black Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene 4 X Divorced 3 Widowed 1 Yes 2 X No specify: Specify iant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner ģ or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Truck Driver Moving Company 12th grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Griffin Joseph Leon Be Elsie Mae Hill 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Peterson-Sister 3910 Boarman Ave, Baltimore, Md 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department o Garrison Forest Vet 6/19/06 Donation 5 Owings Mills, Other Specify Signature of Funeral Service Licar 22 Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part . Enter the disease, or co tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Enter Underlying Cous-(Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 17 per item#23a. <u>g</u>856 X UNPENDED fh -06 ending physician use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day past 12 months Pregnant at time of death Other (Specify Yes 2 No 9 Unknown Unknown the " Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 death? page 1 🗸 Yes No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other After this 1 🗸 Yes ဂ္ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28k Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural death. 5 Pending 1 Yes 2 No hin 24 hours after death the Funeral Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. June 12, 2006 101

Registrar

State

Assistant Medical Examiner 32. Re Istrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2006

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year) JUN 1

111 Penn Street, Baltimore, MD 21201

			1- State of Maryland / Dep	ertment of Health and Mertificate of Death		giene 200	6 19211
Į,			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physici		Charles Hackert		Month June	10 2006	2:00a M
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
L.			Carolina Nursing Home	Denton		Caroline	
8	Funeral	ľ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	ff Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day	h year) 9. Bir	hplace (State or Foreign
	Director		029-12-4696 X M 2 F 93 Yrs.	Midning Days Flours Min.	May 13	1913	MD
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Aaryli I sho	ō					1 ☐ Yes 2 ☐ No
	28a-	Director	MD Caroline Denton 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	
	with Sa or	<u>a</u>	6613 American Corner Road	21629		USA	witt y i
	ns 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe-	cify Yes or No-		rican Indian,
0	or Ites		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit	e, etc.
3	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be neithed at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: W	nite
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Examinat must be millied at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	na	16b. Kind of Business	Industry
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Maryland	should be filed withir or Mental Hygiene. marked other than imatic event, tha M	Be C	Daniel August Lages	Ella fran		· ·	
Ž	2 should and Men Is marke aumatic	ဥ		ing Address (Street and Number or Rural			(in Code)
_	12 : h ar 7 Is trau			Bonnie Brock Rd. C			
ē,	- T = =		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date	ate	20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Tn State	ematory or other place)			
	permit. Departm Importa any inju			2. Name and Address of Facility tate Anatomy Board	455 11	D 1. •	
ñ	P = 1 P = 8		John Joll Boll	ctate Anatomy Board	φοο w.	Baltimore	Street
ľ	57 1		23a. Part I. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory ari	rest,	Approximate Interval Between
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	/Medical		resulting in death) a. Due to (or as a consequence of):		7		10 7103
	Examiner		Sequentially list conditions b.				
(35)	p is	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and I-tran	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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SS	phys the	dical	d				
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	NOD!
ROX	death e atten	hysiclan/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
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ٽر ح	requires that een signed t hould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Hecord	> 4	ompleted	Chronie Obstructive Pou	nonam Ducase	24a. Was a	n 24b. Were au	topsy findings available
_	0 - 0	mo	Chronie Menal Insuff	cienci	autops perfori 1 Yes	med? prior to death? 22000 1 Tyes	topsy findings available ompletion of cause of
VItal	ician: Th certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Death		-	20110
01 <	8	To	examiner? 1 Yes 2 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3□ DOA Other: 4 × Nursing Hom	ne 5 🗌 Reside	ence 6 Other (Spec	ify)
	ding Ph h. After th funeral		27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injury at 29 Work?	8d. Describe ho	ow injury occurred .	
<u> </u>	Attending r death. sctor: Alter by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
UIVISION	of or Attend after death Director:	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	8f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
2	pital urs a erai [O	One Continue of Continue Description				
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filted in by	edical	29a. Certifier (Check only one) 2☐ Medical Examiner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place, at evestigation, in my opinion, death occurre	nd due to the ca d at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of centifier)	29c. License number	2	9d. Date signed (Month	, Day, Year)
	- s + ō		I Colly Jun Olle mo	D35284			
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		1 ,	
			ANDREA AUEN MD 2/9	D35284 S. Washington	STE	Easton 1	10915 04
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.45			Ψ
	Registr	ar	111N 1 9 2006 Magree &	100 MS2!			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4a b C856 6/19/06 WS
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month W. 12.55 PM James . HAJEK Tune 10 2006 4a. Facility Name (If not institution, give street and number, CARROLL HOSPITAL CENTER 4c. County of Death 4b. City, Town, or Location of Death Year Hours Min. (Month, Day, Year) CARROLL If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours 1**/2**0/M 2□ F Yrs. 87 127-09-7599 02/27/1919 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No DE Sussex Milton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 312 Federal St. 16688 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status NEWYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√€No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Major U.S. Army Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rosie unknown James Hajek
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1645 Old Annapolis Rd. Woodbine, Md 21797
ace of Disposition (Name of Date 20c. Location City or Town, State Paul Hajek (son) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 8/4/2006 Arlington, VA Burrier-Oueen Funeral Home and Crematory, 1212 W. Old-Liberty Rd. Winfield, MD 21784
Approximate or complications that caused the death. Do not ist only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION ONE DAY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, and a sequentially sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONARY OBSTENCTIVE 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PROSTATE 24a. Was an autopsy performed 212 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner Examiner the death certificate ba exacuted use as the burial-transit P.O. Box 68760, attending physician Physician/Medical ó detachad þ Division of Vital Records, Be Completed by should be page 2 the funeral director, ٩ Medical Certification: after death. in by within 24 hours a To the Funeral C filled completely

Physician

/Medical

Examiner

Director

Funeral

Completed by

To Be

Funeral

Director

27 is marked other than "naturel", or Itams 23a or 28a-f show traumatic avent, It a Medical Examinar must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should ba filed within nent of Health and Mental Hygiene. snt: If item 27 Is marked other than '

Department of Health a Importent: If item 27 Is eny injury or other tratonce.

Physician

/Medical

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

8

JUN 1 9 2006

16.102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D. 30469

Dr. Nandakumar B. VELLANKI

8850, Columbia 100 Parkway, # 308 Columbia, MD 21045-2377. 29d. Date signed (Month, Day, Year)

11 2006

June

State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Bessie Hudnet Rosina 16, 2006 8:45 A M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8318 Bletzer Rd. Dundalk Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 7, 1915 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Yrs. 217-18-9476 90 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-1 show treumatic event, the Medical Examiner must be notified at Maryland Baltimore Essex 1 ☐ Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Riverside Drive 21221 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced "naturel", **Be Completed** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: if Item 27 is marked oth eny linjury or other treumatic event 8DR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Louis Wittbecker Alberta Mae Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ella May Brown (Daughter) 8318 Bletzer Road, Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cem. June 20, 2006 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signatura a Funeral Sp. non Licensee Marvland 21221 Inter the disease, or complications that caused the death or heart failure. List only one cause such as carriac or respiratory arrest, Imm of the Cause (Final disea to or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Box 68760. physicien by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 | Fetal death ate hes been signed by the ette page 2 should be detached for in the past 12 months?
1 Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No rs after deam.
ral Director: After this cerm.
rab by the funeral director, p. 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D
completely filled 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29d. Date signed (Month, Day, Year) 10 J eted cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 () () § State Registrer Amend #18 Per FH G857 7/21/66 THE Cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15^{Day} **Physician** Juñë 2006 Kuk Hwang 1:00 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Parkville 3 Mapledale Court Baltimore 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 MM 2 □ F 214-06-5617 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 ie marked other than "naturei", or iteme 23a or 28a-f show injury or other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Mapledale Court 21234 South Korea Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ②No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Korean 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'eny injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) 0wner Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Young Hwang Pu-Nam Ja En Ran Nam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Mapledale Court; Parkville, MD 21234 Kum Ja Cho Hwang wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Special 21. Signature of Fundial Service Licenters) 5 Other (Specify) Dulaney Valley Mem Gardens 6/17/06 Timonium, MD 22. Name and Address of Facility 1050 York Road EVI Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (705+1,6 disease or condition resulting in death) 4000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy of Vital 1 Yes 2 NO funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Fo the Hospital or Attending 1 Natural 2 Accident Injun 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: the 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 042910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orleans St, Rn 442 1650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 14, 2006 June Howard R. 10:00 P M Holmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F Yrs. 214-20-6044 79 Aug. 2, 1926 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Directo Hillendale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Terron Court 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white Maryland 21215-003 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjuster Insurance - claims 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Deportment of Heelth and Menta Important: If Item 27 is marked any ligity or other traumatic averages. Charles Holmes 4 1 Rose (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane m. Holmes/Dtr-in-law 8548 Gradien Drive Nottingham, Md. 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 6/17/06 Parkville,Md. 21. Signature of Funeral 8 22. Name and Address of Facility 1050 York Rd Ruck Towson Funeral Home, Inc. Towson, Md. 23a. Part 1. Enter the dise so, or shock, or heart failure. List ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Montas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Norther (Specify) NOS 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled The Centifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

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CHAMUSS. 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certified

Charles St Barmore no mn 0601 IV-32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D58303

29d. Date signed (Month, Day, Year)

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			Decedent's Name (i)	First, Middle, Las	t)						2. Date of De				3. Time of Death
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician, Edward Warren Kearns JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VAINT AGNES HOSPITAL BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) April 30 Birthplace (State or Foreign Country) **Funeral** 1926 Days Hours **1**√□M 2□F Months 217-16-7168 80 Yrs Director MD Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show r then "naturel", or items 23a or 28a-f eho: the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Baltimore Catonsville Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 238 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours efter 1 X Yes 2 □ No 1945 —
If Yes, Give
Year or Dates: 1946 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 1946 "nature!" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 unk unk 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be fills Depertment of Health and Mental Hy Important: if Item 27 is marked oth any julyy or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be James Kearns ٥ Marie Gertrude Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen M. Dawson/daughter 121 S. Fremone Ave. Apt 429 Baltimore MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 500ther (Specify)In state 21. Signature of Enneral Service Licenses State Anatomy Found 655 W.Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNKNOWN /Medical Examiner UNICHOWN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown ģ After this certificate has been signed funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2☐No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 ☑ No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural i Director: A 1 Tes 2 No death. 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli within 24 hours a To the Funerei (Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 10.2006 male manilla P18620 o completed cause of death (Item 23a) (Type, Print) TARANILLA 900 CATON AVE BALTIMORE MARYLAND JAWAL

State Registrar 31. Date filed (Month, Day, Year)

EDWARD W

KEARNS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3:45 P. M MARGARET KARCHER JUNE 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-19-1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 217-09-7467 1 □ M 200 X 90 MARYLAND Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at XX Yes 2 No BALTIMORE CITY MD. N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 KERNEWAY 21212 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Importent: if flem 27 le marked other then "natural", or flem eny injury or other treumatic event, the Medical Examines 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE Specify: ģ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MEAT PROCESSING CO. Elementary/Secondary (0-12) 8 YEARS College (1-4or 5+) SAUSAGE MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RAYMOND Ε. **KYLE** MARY С. FLOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 KERNEWAY, BALTIMORE, MARYLAND, 21212 PURCELL (DAUGHTER) MARY CAROL 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State MOST HOLY REDEEMER 1XXBurial 2 Cremation 3 Removal from State 06-20-2006 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. (R. G. RUTH) TOWSON, MD. 21204 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Candiomyopathy hemic YEVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): O. Bdx 68760. the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 ☐ Yes Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificete 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 9No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ this Alter thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funerel Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ö To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier INVE 16 2006 0 58303

Registrar DHMH 17 Rev 1/2001

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'N. Charles St BATTURE NO ZEROS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32-Registrar's Signature

MALLES

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) ^{Day} 2006 **Physician** June 15, 12:25 P M Lillian Irene Leggore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Rossville Franklin Woods 8. Date of Birth (Month, Day, Year) Feb. 11, 1923 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6 Sax 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 1 X F Pennsylvania 214-38-3449 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 510 Delaware Avenue 21221 items 23a U.S.A. Completed by Funeral filed withIn 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ So 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2XXXIII Specify. If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be innent of Health and Mental I sent: if item 27 is marked o Frank Hill Marion Durborrow 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Importent: if item 27 is any injury or other tratence. 510 Delaware Avenue, Essex, Maryland 21221 Charles Leggore, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition *Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. June 19,2006 Baltimore, Maryland ' 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ō 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ pe 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed: 1 ☐ Yes 2 ☐ No 2 10 No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitei or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 Tes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide To the Hospital within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D53465 MD 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) O Glen Burnie MD 21061 Road 7845 OAKWOOD am 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 9 2006 Registrar

DHMH 17 Rev 1/200

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Of State Registrer Amend #19a Per FH G856 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2:57 A M JUNE 15 2006 LURIE MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Month Day Year) 06/20/1920 5. Social Security Number 7. Age (In yrs. last birthday) Months **Funeral** 1 □ M 2 🔽 F PA 85 219-01-2559 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ir than "naturel", or items 23a or 28a-f ehours the Modicel Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 7920 SCOTTS LEVEL ROAD Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give WHITE 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY ADMIN. SUPERVISOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental Fig. ZIMMERMAN GARFINKEL REBECCA JACOB 19b. Mailing Address (Street and Aumber or Rural Route Number, City or Town, State, Zip Code)
ITH OT OUP ∩ DT € U 19a. Informant's Name/Relationship (Type, Print) - OWINGS MILLS, MD 21117 nt of Health a 3716 THOROGHBRED LANE CHARLES LURIE / SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Depertment of Important: If eny Injury or once. 06/16/2006 OWINGS MILLS, MD HAR SINAI CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) .O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 🕽 No 25. Was case referred to medical 26. Place of Death | Check only one funeral director, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Matural 5 Pending investigation 1 ☐ Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 15 2006 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13, June Louise M. Marks 2006 11:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore. Nottingham 4305 Slater Avenue 8. Date of Birth (Month, Day, Year) March 12, 1944 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕡 F Maryland 62 Director 212-42-5595 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director Maruland Baltimore Nottingham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4305 Slater Avenue 21236 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Importent: If item 27 Is marked other the eny injury or other treumatic event, Italy once. Shoppers Food Store Baker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magdaline Sour Drasal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Marks, Sr. (husband) 4305 Slater Avenue, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Entombrent Dulancy Valley Maus. 6/16/2006 Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Buin a.U 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical the ass IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page this certificate 1 Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a filled 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Road Glen Burnie MD 21061 OAKWOOD Muneses 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 9 2006

			For State Registrar	State o	f Marylan		artment of F		ind Mer		iene eg. No.	2006	19	1224
	3.	重	Decedent's Name (First, Middle,	Last)						Date of Deat	th		3. Time	of Death
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	/Medic Examin		4e. Facility Name (If not institution,	give street and nui	mber)		4b. City, Town, o	or Location of		10(114	_	county of Deat		. 101
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	Funeral	,		S Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth	Vacel			e or Foreign
	Director		214-44-6138	X □M 2□F		59Yrs.	Months Days	Hours		(Month, Day,			MD	
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	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What Co	ountry?	
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	oms erms	Funeral	11. Marital Status unk	12. Was Dece Armed Fo	edent Ever in U. prces?	.S. 13.	Was Decedent of I If Yes, specify Cub	tispanic Orig an, Mexican,	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14	 Race - Ame Black, White 		
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Maryland	d 2 should be f th and Mental I 7 is marked of traumatic eve	2	19a. Informant's Name/Relationsh	in (Type Print)		10h Maili	ng Address (Street	and Number	e or Pumi Pr	oute Alumber	City or	Tour State	Zin Code)	
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	of Health of Health Item 27 i		Harbor Hospita 20a. Method of Disposition	1	120b. F	lace of Dispo	South Ha		St	Balto		ation - City or		
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	tmen tant		4 □Donation Sy Other (Sp		ite	1 0	0. 11	1						
Baltimore,	pernit. Page Department of Important: If any Injury or once.		21. Signature of Funer J Service L	icensee	-	2	State Ana	tomy E	Board	655 W.	Ba1	Ltimore	Stre	et
	40240		1 minus	al-			Baltimore						Approxir	
R			23a. Fart1. Enter the disease, or of the hock, or heart failure. List of	only one cause on e	each line.	n. Do noten	ter the mode or dyl	ng, such as o	cardiac or re	spiratory arr	est,		Interval I Onset ar	Between
	Physician		Immediate Cause (Final disease or condition	_ a	METAP	SOLIC	ENCEPI	HA LO	PATH	4				DNS
	/Medical Examiner		resulting in death)	Due to	(or as a conseq					,				
L,	LAMINITE	_	Sequentially list conditions,	b			GAN	A1 211	RE				9.	DAYS
	D ti	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq									- 114
	and tran	cam	that initiated events resulting in death) Last	c.	(or as a conseq		SHOPE	HILIP	4 SAM	DROM	£.		UNK	-MOWH
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8760	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d		_						_	7	
9	eath certific attending p	Me	IF FEMALE:	00- 16							1			7
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live I	tcome of pregna pirth 2 ☐ Fete	death 3	⊒Ectopic pregnanc	у			23	3d. Date of del Month	ivery Day	Year
	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐ Unkn	nant at time of d own	leath 5 [Other (specify) _						/	
о. О	that the de led by the a detached t	Completed by Physician/Me	Part II. Other significant condition	se contribution to d	eath but not res	ulting in the I	indorhina aqueo ai	upp in Part I		23e Did to	hacco us	e contribute to	the cause	of death?
Ś	igned be det	þ	Patti. Other significant condition	SERSIS	eath but not les	anning in the c	iridenying cause gr	v o n in Fanti.			es 2			Unknown
ord	w require been sig should b	ted		356212							63 Z	140 3 11	obably -	
Vital Records,	elawi hasb	ple		PNEUM	ONIA					24a. Was a autops	SV I	24b. Were au	utopsy lindin completion of	gs available of cause of
<u> </u>		P								perform	med?	death? 1 ☐ Yes	NO DE	
<u>ta</u>	Attending Physician: The in death. ector: After this certificate his by the funeral director, page	Be (25. Was case referred to medical examiner?					26. Place	ol Death (C	heck only on	10)			
2	Physic this ce al dire	70	1 ☐ Yes 2 ☑ No	Hospital: 1,	lnpatient 2□	ER/Outpatie	nt 3□ DOA Ot	her: 4 ☐ Nui	rsing Home	5 🗌 Reside	ence 6	□Other (Spe	cify)	
0	neral	ü	27. Manner of Death 1>□ Natural 5 □ Pending	28a. Date (Mon	ol Injury th, Day Year)	28b. Time o	of 28c. Inju	ry at	28d	. Describe h	ow injury	occurred		
Division of	ath. or: Al	atic	2 Accident investig	ation		. ,	M 1	Yes 2 □N	No					
<u>Kis</u>	Protected	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place	e of Injury - At he	ome, larm, st	reet, lactory, office		281.	Location (Si City or Town	treet and n, State)	Number or Ru	ural Route N	umber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:		7	,=,=,=									
	hour hour uner ly fill	m	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the Examiner: On the b	e best of my kno	owledge, dea	th occurred at the to	me, date and	d place, and	due to the c	ause(s) a	and manner as	stated.	a(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	one)	and mar	iner stated.									
	To 1 To 1	Σ	29b. Signature and title of certifier	4N/	/		29c. Licen	se number		2	9d. Date	signed (Monti	h, Day, Yea	r)
?			•	1	LAY KHIN	V, MD	RI	5 00	٥		MAY	131,2	006	
			30. Name and address of person v	vho completed cau										
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	Sta Regist		31. Date liled (Month, Day, Year) JUN 1 9		egistrar's Signa	ature A	mile							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2006 May 25, 9:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington Fort Washington Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Yrs. Director 256-66-1234 103 Oct. 28,1902 Georgia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminational be notified at Md. Prince Georges Fort Washington 1★ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12308 Horizon Court 20744 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife 7th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic evant <u>once.</u> Be George Duheart Mattie Jane Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry McAdoo/Grandson 4328 18th St., N.W. Wash. D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) May 31, 2006 Pineview, Ga. Mattie Richland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma 716 Kennedy St., N.W. WDC 20011 Approximate Interval Between Onset and Death Physician months /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident months Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Hypertension years been signed by the attending physicien and should be detached for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 20 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1 Yes 2/2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other Certification: To IX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t or Attanding 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarai C 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D32890 6/12/06

State Registrar 31. Date filed (Month, Day, Year)
JUN 1 9 2006

Baltimore, Maryland 21215-0036

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Division of Vital Records,

H. Herbert Washington, M.D. 11701 Livingston Rd, #205 Ft. Washington Md. 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Рм 15, Monize 8:05 Cecelia 2006 Lucille June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore 8124 Callo Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Dec. 9, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F Guyana 62 098-46-8852 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f shov tre Medical Examiner must be notified at 1 Yes 2 No Rosedale Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 USA 8124 Callo Lane death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black Yes. Give þ If Yes, Give Year or Dates: 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Computer Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental h Pages 1 and 2 should be John Monize Christina Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health as Important: If item 27 is any injury or other traugonce. 15003 Ridge Chase Court, Bowie, Maryland 20715 Marcia Assanah (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State June 23,2006 Baltimore, Maryland Gardens Of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fun and Service Lieur see 22. Name and Address of Facility
Pruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Acute Myocardial Infarction **Physician** IhRS /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Attending Physician: The law requires that the deeth certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2/2/No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmad? 2∐-No certificete 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this Certification: To After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural To the Hospitel or Attending within 24 hours after death. To the Funersi Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0044018 ugenelbah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6565. N. Charles St. OBAH 31. Date filed (Month, Day, Year) State Registrar 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas S. McFee 2006 12:15 P M June 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 19, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 579-38-4732 Director 75 Wisconsin Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. snt: If item 27 is marked other than "naturel; or Items 23a or 28a-f show 10c. City, Town or Location ?7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Madical Enanther must be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Ashton Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Tucker Lane 20861 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No 1953 – If Yes, Give Year or Dates: 1956 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ٥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Assistant Secretary for Personnel Administration 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health Elementary/Secondary (0-12) College (1-4or 5+) and Human Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leon W. McFee Marguerite Morris ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. McFee / Wife 1213 Tucker Lane, Ashton, Maryland 20861 other 20b. Place of Disposition (Name of cometery, crematory or other place)
Rocky Gap Veteran's 20a. Method of Disposition June 19, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland 2006 Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Monttomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Pancreatic Carcinoma One Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760,< Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 8 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ⊠ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Alter 1 X Natural Injury 5 Pending after death.
I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD060335 June 14, 2006 Paul Pan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Bannen, M.D. 18111 Prince Philip Drive, #327, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

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Dhusia		1. Decedent's Name (First, Middle, La						2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Med		Alvin Henry						June	14,	2006	8:55 P M
Exam	iner	4a. Facility Name (If not institution, giv				Town, or Local				unty of Death	
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deeth	Jera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	dent of Hispani	c Origin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	
is 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mentai Hygiene. Itam 27 is marked other than "natural", or itema 23e or 28a-f show other traumatic avant, its Medical Example must be notified at	۾	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 ⊡ Yes		ecity:	Hican, etc.)	1	Btack, White, ecity:Whit	
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Date: 1 Departm Importa		21. Signature of Funeral Service Lice		2	2. Name an	nd Address of F		himunek			
Department of the post of the		Burain Ce-L	elle					Baltimo)			
Physiciar	_	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resutting in death)	plications that caused the death one cause on each line.	te.	ler the mod	e ot dying, suc		or respiratory ar	rest,	7	Approximate Interval Between Onset and Death
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The law requires that the death certificate be executed at has been signed by the ettending physicien and page 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	t death 3	□Ectopic pr □ Other (sp				23d.	Date of delive	ery Day Year
T.	4	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying c	ause given in F	Part I.	23e. Did to	obacco use	contribute to the	ne cause of death?
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hysician: The law his certificate has b	B	25. Was case reterred to medical	Description				Ptace of Death	(Check only o	ne)		
Physic ruthis o	P			ER/Outpatier				me 5 X Resid			y)
ling f	0	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o tn i ury		28c. Injury at Work?		28d. Describe i	now injury oc	ccurred	
VISION OF VICE * Attanding Physician: ar death. ractor; After this certific by the funeral director,	le al	2 Accident investigation 3 Suicide 6 Could not be	De 290 Place of Injury At he	ome tarm st	M reet factors	1 Tes		28t. Location (S	Street and N	umber or Rura	ul Route Number.
ital or A	Certification	4 Homicide determined	building, etc. (Specifi	y)				City or Tov	vn, State)		
To the Hospital or Attending Phwitin 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	led ical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exe	hysicien: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the time, da , in my opinion	te and place, , death occurr	and due to the e	cause(s) and date and pla	d manner as s ice, and due to	tated. the cause(s)
To the within To the Comp	Ž	29b. Signature and title of certifier	0. 0		290	c. License num	ber		29d. Date si	gned (Month,	Day, Year)
ار	X	In Tured	Staff Plysice	en	1 -	19716	1	1	15/	06	
12	~	30. Name and address of person who MI LUDIZL AVE: 14	Completed cause of death (Item J.4 B.V.M.L. 4.7	n 23a) (Type,	Print)	r Ave	- 121=	Timure	mer	1214	
S Regis	tate	31. Date filed (Mg/t/) (Var) YGr) 20	06 St. Registrar's Sign	mure /							

		4	For	State of Mar	yland /	Departmen Certificate				iene _{eg. No.} 2001	5 19229
		_ \	State Registrar			Certificati	- OI Deali		2 Date of Deat		3. Time of Death
	Dhuaiaia		Decedent's Name (First, Middle, Last)						Month	Day Year	2.10 DW M
	Physicia /Medic	al le		Huu Phu l	Nguyen			(D 15	June	14, 2006 4c. County of Dea	2:10 PM M
	Examine		la. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Location	n of Death			
			Shady Grove Ad		ospita	1	Rocky:		B. Date of Birth		thplece (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b	Yrs. Months		Min.	(Month, Day,	, Year) Co	ountry)
	Director		212-41-2146	, (,, 20)	62	115.			eptember	16, 1943	Vietnam
3	2	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
	ahov	. 1					0 - 1 - 1				1 ☐ Yes 2 No
:	P P	5	Maryland Montg	omery		10f. Zip	Gaither	rsburg		log. Citizen of What C	ountry?
3	or 26	Director	10e. Street and Number			101. 24					
	be filed within 72 hours after death with the Maryland Hygiene. I be Hygiene. I chief then "natural", or items 23s or 28s-f show avent, the Medical Examinar must be notified at swant, the Medical Examinar must be notified.		642 Whisper	ing Wind C	ourt	12 Wes Door	208	77 Origin? (Spec	ify Yes or No-		d States encan Indian,
V	ep .	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		If Yes, spe	dent of Hispanic C city Cuban, Mexic	an, Puerto P	lican, etc.)	Black, Whi	te, etc.
2	or li		1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	,	1 🗆 Yes	2 No Specific	ty:		Specify:	Asian
ž	ural'.	d by	3 Widowed 4 Divorced		1/	6a. Decedent's Usu	al Occupation			16b. Kind of Business	
ភ	72 h	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give kind of wo	ork done durina m	ost of working	g		
7	within 72 ene. then "nei he Medic	ш	Elementary/Secondary (0-12)	Coltege (1-4or 5+	-)		Operator			BP S	olarex
N	led w lygie her t	ပိ	17. Father's Name (First, Middle, Last)						(First, Middle,	Maiden Sumame)	
ב	htal H	Be		1 37	_					Deo Le	
$\frac{8}{2}$	Mer Mer Mer Mer Mer Mer Mer Mer Mer Mer	ုင		oanh Nguye	n 1	9h Mailing Addres	s (Street and Num	n <i>ber</i> or Rura		er, City or Town, State,	Zip Code)
Maryland 21215-0036	2 should be filed within and Mental Hygiene. I is marked other than raumatic event, the Mental County.		19a. Informant's Name/Relationship (T)	ype, riini)							ryland 20877
	and ealth m 27 her tr		Boi Tran/ Wife		20h Place	of Disposition /Na	me of	D	ate	20c. Location - City of	r Town, Slate
9	of H of H M Ita		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removat from State	Mo	etery, crematory or ntgomery	other place)	Jui		D .1 1	M 1 1
Ē	Pag ant: ury		4 ☐ Donation 5 ☐ Other (Specify)	Cr		T	17.	2006	Bethesda,	maryiand uneral Home/
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monta Important: If Item 27 is marked any injury or other traumatic a once.		21. Signature of Funeral Service Licens	n /		Bethes	da-Chevy	Chas	Inc.	_7557 Wisc	uneral Home/ onsin Avenue
m	89E 29		Man)	Int.	M0033	5 Bethes	da, Mary	Land 2	20814-3	501	Approximate
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	Mications that caused one cause on each lin	the death. I e.	Do not enter the mo	de or dying, such	as cardiac c	i respiratory at	11031,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	•	Non	Small Cel	1 Carcin	omia	of Lung		Months
1	/Medical		resulting in death)	Due to (or as							
	Examiner		O contain the line constitution	b							
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury	Due to (or as	a consequer	nce of):					
V	be executed sicien and burial-transit	Examine	that initiated events	c							
Ć	exec n an rial-tr		resulting in death) Last	Due to (or as	a consequer	nce of):					
760,	e be ex sicien e buria	cal		d							
.89	leath certificate t attending physi I for use as the b	edi									
Box	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnanc	y eath 3□Ectopic	pregnancy			23d. Date of d Month	telivery Day Year
Ď	d for	Physician/Medi	in the past 12 months?	4☐Pregnant at			specify)				ŕ
P.O.	by the a	hys	9 Unknown						20 514		to the cause of death?
	The law requires that the death certificate are has been signed by the attending physpeg 2 should be detached for use as the	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ng in the underlying	cause given in P	art I.			to the cause of death?
Records,	uires Igls r								1 🔼	Yes 2 No 3	Probably 4 ☐Unknown
Ö	w requir been s should	lete							24a. Was		autopsy findings available to completion of cause of
Re	has ge 2	Completed							perfe	ormed? death	es 2 No
a	n: The		Of the open referred to modical				26. P	Place of Deat	h (Check only		
of Vital	sicle: certif recto	Be	25. Was case referred to medical examiner?	Hospital: 1 V Innati	ent 2 🗆 FI	R/Outpatient 3□				idence 6 Other (S	pecify)
of	Phys this	15	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Inju	iry 2	8b. Time of	28c. Injury at Work?			how injury occurred	
UC	ding After fune	lo E	1 Natural 5 Pending investigation	(Month, Da	y rear)	Injury M	1 Yes	2 🗆 No			
Division	death tor:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At horr	ne, farm, street, fac	ory, office		28t. Location	(Street and Number or own, State)	Rural Route Number,
Σ	or A offer Direction by	rti	4 Homicide determined	building, e	ic. (Specify)				Ony of 10	J, J.(10)	
ب	To the Hospital or Attending Physiclen: The I within 24 hours effer death. To the Funerel Director: Affer this certificate ha completely filled in by the funeral director, pege	2	29a. Certifier 1⊠ Certifying P	hvsician: To the best	of my know	ledge, death occurr	ed at the time, dat	te and place.	and due to the	e cause(s) and manne	as stated.
	Hos 14 ho Fund tely f	edical	(Check only 2 Medical Exa	miner: On the basis of and manner s	of examination	on and/or investigat	ion, in my opinion,	, death occur	red at the time	, date and place, and	due to the cause(s)
	the the mplei	Med	29b. Signature and title of certifier	Sile mainer o			29c. License num	ber		29d. Date signed (M	onth, Day, Year)
	7 × 10 CO CO CO CO CO CO CO CO CO CO CO CO CO		171					0/50		Tarra - 1	4 2006
	.^		Chihe lyper	me		00-) (T T	D4	2452		June .	4, 2006
	1()		30. Name and address of person who	completed cause of	death (Item :	zsa) (Type, Print)		#20		errilla Mas	ex.land 20250
	10		Chitra Rajagopa	20 Denici	trare Signatu	IFA D		ve #32	/, KOCI	ville, Ha	y Lanu 20000_
		itate		2006	o orginali	H Span	()				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 1 per doc 9856 6-19-06 yt. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) Charles Owens Jr. 2. Date of Death 3. Time of Death Month Year **Physician** 11:15A thodacs 2006 06 u /Medical 4a. Facility Name (If not institution, give street and number)
Ruxton of Pikesville/75 4b. City, Town, or Location of Death 8 altimo **Examiner** 7 Sudbrookla. Boltmare, MD 21208 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days XIXM 2□F 84 Director 215-14-9494 MD Usual Residence of Decedent death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example must be notified at No Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3827 Callaway 21215 Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify: à 3 Widowed 4 Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Health Care Finance mentary/Secondary_(0-12) College (1-4or 5+) 12th grade 8yrs Specialist Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Collins Charles R. Owens Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ly 3827 Callaway Ave, Baltimore, Md Jean Owens-Wife 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Marial 2 ☐ Cremation 3 ☐ Removal from State ₩ 5 permit. Pages Department or Important: If any Injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 6/15/06 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Euneral Service Licensee ala March 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final AITHISMIGH **Physician** ENDSTAGE cas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown à signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð PNEUMONIA ASPIRATION 1 Yes 2 No 3 Probably Winknown filled in by the funeral director, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No Was case examiner? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After? Attending 1 Nature. 2 Accident Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 0 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

6565 N. Charles St

BaltoMD

Sunte 209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Desery.

as lines may

		1 - For State Registrar	State of Maryland / Depa	artment of Health and l rtificate of Death	Mental Hygie Reg.	2000	19231
		Decedent's Name (First, Middle, Last,			2. Date of Death		3. Time of Death
Physic /Medi		JEROME	OFFUTT			Day Year 5th 2006	6:45 PM
Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		4c. County of Death	7
		Levindale		Baltimore		N/a	
Funeral		5. Social Security Number 6. Sec	N all E	Il Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
Director		21/-24-4204	75 Yrs.			1930 Mary	
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			0d. Inside City Limits
Mary	ō	Manuland Paltimana	D 1 11 .				1 ☐ Yes 2 ☐ No
28a	rec	Maryland Baltimore 10e. Street and Number	Randallsto	10f. Zip Code	10g.	Citizen of What Cour	
3a o	Ö	3806 Elmcroft Rd.		21133			•
If Z 12.15-0050 filed within 72 hours after death with the Maryland Hygiene tither than "naturel", or Items 23a or 28a-f show ont, the Medical Examinat must be notified at	Funeral Director		12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	nited Stat	an Indian,
or Ite	Ē	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No 1951 —	f Yes, specify Cuban, Mexican, Puert	o Hican, etc.)	Black, White,	
ours Feri	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1953	I ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
72 h	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give	lent's Usual Occupation kind of work done during most of wor	king 16b	. Kind of Business/Inc	dustry
within the the the the the the the the the the	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)			
Hygie Ther I		12th 17. Father's Name (First, Middle, Last)	Westi	nghouse	ne (First, Middle, Maid	ssembly	
yicallu ∠1.∠ buld be filed with Mental Hygiene, arked other tha	Be C	J. William Offutt				oen Sumame)	
2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (Ty	pe. Print) 19h. Mailín	INCLITE I g Address (Street and Number or Ru	F. Gleason	ty or Town State Zin	Codel
; Mic and 2 saith ar n 27 is ser treu			proprieto saci				
ite, INIAI VIAILU ZIZIOOOOO s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Ithealth and Mental Hygiene. Itiem 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at		Ellen Davis (niec	20b. Place of Dispos	aker School House sition (Name of natory or other place)	Date Free	and Mor 2	1053 State
Page nt: # ry or		Magazial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)		Mem. Park 6/20	/2006 Syke	esville. M	D
Definit. Pages 1 an Deportment of Heal Importent: If item 2 any njury or other once.		21. Signature of Funeral Service License		. Name and Address of Facility			7
Depoi		Sould d. K	elle Bur	rrier-Queen Funer	al Home ar	nd Cremato	ry, P.A.
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not enter	er the mode of thing, such as can be	or respiratory	ield, MD 2	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CORONARY ARTE	MA DICEOCE			Onset and Death
/Medical		resulting in death)	Due to (or as a consequence of):	M .Dagase			192
Examiner	١. ا	Sequentially list conditions,	METASTATIC RET	VAL CELL CANC	ER		144
sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence ol):			1.	
icate be executed physician and sthe burial-transit	aiE						
ficate ficate phys	edicai	C	•				
ath certi		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delive	rv
The law requires that the death certifules that the death certifules that the death certifules been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)			Day Year
by the lacke	hys	9 🗆 Unknown	9☐ Unknown				
ss tha	by P	Part II. Other significant conditions con	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	course contribute to the	e cause of death?
law requires t as been signe 2 should be					1 Tes	2 No 3 Prob	ably 4 Unknown
as be	Completed				24a. Was an autopsy	24b. Were autop	sy findings available
sicien: The law scertificate has birector, page 2 s	Con				performed	death?	
ricien: Ticien: Sertifical	Be (25. Was case relerred to medical examiner?		26. Place of Dea	th (Check only one)		
Physic This ca	To	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Outpatient	3 □ DOA Other: 4 □ Nursing H	ome 5 Residence	6 ☐ Other (Specify	,
Attending Physicien: The art death, rector: Attentions certificate his by the funeral director, page	00:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
tending seath. tor: Afte the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
or All	Certification:	4 Homicide determined	28e. Place of Injury - At home, larm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
spital ours serel filled	C	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause	u(s) and manner as et	atod.
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	(Check only 2 Medical Exeminates)	er: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occur	red at the time, date a	and place, and due to	the cause(s)
Withir To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, L	
		Worna M. E	uerly mo	D054739		JUNE 16 M	2006
1541	-		mpleted cause of death (Item 23a) (Type, F				
17,		2434 W. Belve	ere Avenue, Ba	Ulimore 21215	·		
St Regist	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signature	P.)			
riegist	aı	JUN 1 9 2006	ANKERED AS PERSON				

		1- State of Marylan		artment o		nd Men		ene g. No.	15	19232
Physi /Med		Decedent's Name (First, Middle, Last) VERNICE R. ODOMS				1	Date of Death Month UNE 1		Year	3. Time of Death 1:36 PM
Exam		4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL		L	n, or Location of AUREL			4c. County of PRINC		EORGE'S
Funera Directo		5. Social Security Number 496-38-5112 6. Sex 1□ M 2 7. Age (In yrs. 1 1□ M 2 7. Age (In yrs.	ast birthday) Yrs.	If Under 1 Ye Months Da			pate of Birth Month Day 0 / 1 3 /	1934		place (State or Foreign ptry) ANSAS
Maryland f ahow	tor		, Town or Lo	cation ID CITY	Y.					10d. Inside City Limits 1 X Yes 2 ☐ No
death with the Maryland ma 23e or 28a-f ahow rmust be rediffed at	I Director	10e. Street and Number 236 IRONSHIRE SOUTH		10f. Zip Cod 20	724			g. Citizen of W	hat Cou	ntry?
OUGO hours after death	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 Married 1 □ Yes 2 Married 1 □ Yes 2 Married 1 □ Yes 2 Married 1 □ Yes 2 Married		Was Decedent f Yes, specify 0	of Hispanic Orig Cuban, Mexican, No Specify:	in? (Specify Puerto Rica	Yes or No- n, etc.)		, White,	can Indian, etc. ACK
ING ZIZIS-UUSO be filed within 72 hours after death with the Marylar lat Hygiene. d other than "netural", or itema 23e or 28a-f ahow event, tra Medical Evarinat must be rottlind at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2TH College (1-4or 5+) 2 +	(Givə litə. l	dent's Usual Ockind of work do DO NOT use re	ne durina most	of working	1	SEARS		dustry PRPORATION
	To Be (17. Father's Name (First, Middle, Last) BISMARK ROBINSON					st, Middle, M MALLE	aiden Sumame TT	9)	
Gore, Maryla ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic	4. 6	19a. Informant's Name/Relationship (Type, Print) JENKINS ODOMS, JR / HUSBAN	19b. Mailir D 23	ng Address <i>(Str</i>	eet and Number NSHIRE	or Rural Ro. SOUT	ute Number, H , MA	City or Town, S RYLAND	ÇĮ	TY MD
SAITIMOFE Sermit. Pages 1 a Department of He mportant: if item		X	emetery, crer	sition (Name of natory or other NATI	place) CEM	Date 7/12/	7	oc. Location - 0		
Baltimor permit. Pages Department of Important: if its		21. Signature of Seneral Service Licensee	22 4 4	. Name and Ad	dress of Facility	HOWE	LL FU HTS A	NERAL VE, BA	HOM LTI	E 21207 MORE, MD
Physicia: /Medica		23a. Gall. Enter the disease, or complications that daused the death proof or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MY Due to (or as a consequence)	OCARD		dying, such as c		piratory arre	st,		Approximate Interval Between Onset and Death 2 HRS
BOX 68/60, eath certificate be executed attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ARTERIOS Due to (or as a consequence of the	CLERO uence of):	SIS HE	ART DI	SEASE	2			
. 0 00	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XiXNo 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify				23d. Date Mon		ery Day Year
ords, F.C. requires that the desensioned by the a	by P	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause	given in Part I.					ne cause of death?
The taw The taw ate has b	Completed	CEREBRO VASCULAR DISEAS	E		-	_	24a. Was an autopsy perform 1 🗆 Yes 2	ed? de	ior to co.	psy findings available mpletion of cause of 2X No
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To the Hospital within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 13. Certifying Physician: To the best of my known and manner stated.	wledge, death	occurred at the	e time, date and ny opinion, deati	place, and on occurred at	lue to the car the time, da	use(s) and mar le and place, a	ner as s	tated. o the cause(s)
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7		30. Name and address of person who completed cause Neath (Item	TDII	/.	1AV 008	N DUS	EN RO	AD		
S Regis	State strar	THOMAS H. BURGUIERES, MD 31. Date filed (Month, Day, Year) JUN 1 7 2006 32. Registrar's Signa		EMERG.	DEPT.	, IAL	JREL,	MD 2	070	7

State of Maryland / Department of Health and Mental Hygien [] 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** George John Parrish, Sr. 9:00 P M June 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9111 Sandra Park Road Baltimore Perry Hall | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Sept. 16, 1929 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 **№** M 2 🗆 F Months Days 218-22-3355 Yrs. 76 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar near of Health and Mental Hygiane. And Health and Mental Hygiane. And It is the marked other than "natural; or litems 23a or 28a-1 show and it is Mudical Exartha must be notified at my or other traumatic event, its Mudical Exartha must be notified at Funeral Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9111 Sandra Park Road 21128 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 □ No
If Yes, Give Kortean
Year or Dates: Confict 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Be Completed by Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Leasing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Parrish Hattie Link 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 Sandra Park Rd., Perry Hall, MD 21128 George J. Parrish, Jr. (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Department or Important: If any injury or Moreland Mem'l Park 6/17/2006 Baltimore. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buin a Wille 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocked /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Prukinson as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 hrosic for use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Tes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20807 14/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 1 9 2006 Registrar

			For		ryland / Dep			-	_	
			1 - State Registrar			rtificate of			g. No.2 UU6	19235
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	4a. Fecility Name (If not institution, give		ince			June 15		9:45 P. ^M
7	Examir	ier	1 N. Symington A	·		Catons	or Location of Dea	itn	4c. County of Dea	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday,		r If Under 24 Hr			thplace (State or Foreign ountry)
	Director		220-12-8529	☐M 2[X]F	91 Yrs.	Wioriuis Days	TIOUIS IVIII	Aug. 10,		ginia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	a-f sh	ctor	Marvland Baltimon	re	Catonsvi	111e				1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
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(0	r terr	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N	0	_		Specify Yes or No- rto Rican, etc.)	Black, Whi	
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pu	be filed ital Hygie of other event, II	BeC	17. Father's Name (First, Middle, Last)		110111011	.0.1002	18. Mother's Na	ame (First, Middle, N		
yla	2 should be and Mental is marked c	To	Henry E. Brooks				1	Kate Dyk		
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	t Health item 27 i		20a. Method of Disposition	Son	20b. Place of Dispo	Symin to osition (Name of matory or other pla	nom-co-planters in		ille, MD 2 Oc. Location - City or	
E O	nit. Pages artment of i ortant: If it injury or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Lorraine		' 1	19/2006	Woodlawn,	Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Foneral Service Licent	9011	2: F	2. Name and Addr	ess of Facility St	erling Asl	nton Schwa	b Witzke
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	Dhusisian		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	8.	(/) / ×		St,	Approximate Interval Between Onset and Death
12.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	LAN	toretus	1		Herris
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	₹ \	niner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included exact	Due to (or as a	consequence of):					
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x 68	The law requires that the death certificat ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	20. 11						077
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	To the Hospital or Atts within 24 hours after de To the Funerel Directo completely filled in by th		Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	my knowledge, death	h occurred at the t	ime, date and plac	e, and due to the cau	ise(s) and manner as	s stated.
	ithin 2 o the l	Medical	29h Signature and title of certifier	and manner state	80.	29c Licen	se number		d Date signed (Mont	h Day Veed
	To To con		1	N		370	-786	É	-19-6	y. · · · · · · · · · ·
	1.		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print)	1 (.10	Burnin	mo) 2,5	260
	Ψ		31. Date filed (Month, Day, Year)	- MO)	's Signature	alet 1 P	1 416	1 100 11 61		00
	Sta Registr		11IN 1 9 2006	Deliaz a	's Signature	le				
			TUIN LOUD		-					

Orestes Perez 06 - 1373Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S Amend item#23a, per 12858, 8119 06 TT Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registra Amend UNKNOWN #19a&b& #10a=c Per Ana Bd G856 6719/06 Jf 2. Date of Death 3. Time of Death Day 2006 FEB. 24, **Physician** 1210 Рм Orestes Perez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. BATTIMORE CITY Examiner 800 blk. GUILFORD AVENUE UNDER I-83 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 M 2□F 72 Nov 29 1933 Director unk Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State other then "natural", or items 23a or 28a-f show vent, the Medical Examinar must be notified at unk Anne Arundel 1 XYes 2 □ No Md Glen Burnie Director unk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 713 East Shore Road unk Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unk Black, White, etc. Peges 1 end 2 should be filed within 72 hours after 1 Yes 2 No unk
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Y□Yes 2□No Specify: unk Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be unk ၉ unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unk item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place) O.C.M.E. 20c. Location - City or Town, State 20a. Method of Disposition Depertment of P Important: if ite any injury or ot anca. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 22, Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Foneral Service Licenses mass 20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Cause (Final disease or condition resulting in death) Hyperthermia complicating diabetic ketoacidosis HYPOTHERMIN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by certificate has been signe irector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE ို 1 X Yes 2 □ No this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Naturat 5 Pending FOUND IN A COLD ETUNIZON YEM 1 Yes 2 DNo s after death.

I Director: Af d in by the fur 11:508 Fano 2-24-06 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 800 BLY GUILFORD BUT BLUTHOME MO BYPASS ULOUR within 24 hours a To the Funeral I completely filled ro the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25, 2006 FEB. O.C.M.E The yould Maying 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 MARGANITA A. KOREU 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 9 2006

DHMH 17 Rev 1/2001

ORIGINAL

06-03990 Collins Phillips

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State	C	Certificate of	Death		R	teg No.	00 1923
Physiciar	1/	Decedent's Name (First, Middle,Last)					2. Date of Dea Month	Day Year	3 Time of Death
Medical Examin		COLLINS PHILLIPS					June 10,	2006	1742 hrs
	4	4a. Facility Name (if not institution, give	street and number)		b. City, Town, o		Death	4c. County of De	ath
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Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Ye Months Da		Min		eign
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, MD and 2 shou ealth and 7 is rem 27 is remarked		A. E. PHILLIPS/WIFE					LTIMORE, MD		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shur other tranunatic event, the Medical Examiner must be notified at once	Γ	20a. Method of Disposition 1 X Burial 2 Cremation 3		Ob. Place of Dispos crematory or other		emetery,	Date	20c. Location - City 3620 WITKI Dundauk	or Town, State
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Baltimore, permit Pages I at Department of He Important: If ite injury or other to	r	21. Signature of Funeral Service License						IS, JR. FUNER	
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Box 687 e death certifi	sician	past 12 months?	4 Pregnant at time of	-6 -1 1 -	her (Specify)				
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Spital Dours nours and filled	Certification:	4 Homicide determined	(Specify)						
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To the within To the comple	Medical	one) 2 Medical Examiner: 29b. Signature and title of certifier	and manner stated			nse number		29d Date signed (
	2	255. Signature and title of certifier	M			.M.E.		June 11, 2006	
		SAL MINET							
(2)		30. Name and address of person who c Susan Hogan MD. Assis	ompleted cause of death (tant Medical Exami		n Street, Ba	altimore. Mi	D 21201		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Bronislaus Τ. Ploski June 14, 2006 11:20 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 4409 Bel Pre Road Rockville ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1X M 2 T F 76 Yrs August 17, 1929 047-22-7863 Connecticut Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4409 Bel Pre Road 20853 United States 'natural', or Itama 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No ff Yes, Give Year or Dates:Korean 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itan any injury or other traumatic avant, the Medical Example. ODG. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2K No Specify Specify: þ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) IBM Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ploski Lizak Bronak Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas F. Ploski/Son 8951 East Autumn Sage Street, Tucson, AZ 85747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 16, 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 2006 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee John P chaplen M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) 4 months Physician Colon Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Į in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown À signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2K No Hospitel or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2₺ No 1 Inpatient 2 ER/Outpatient 3 DOA this tor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 🛛 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and D0061083 June 15, 2006 0 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul M. Thambi, M.D. 9707 Medical Center Drive #300, Rockville, Maryland 20850 32. Resistrar's Signature State JUN 1 9 2006 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time, of Death **Physician** Month Year Otis Oueen 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner naryland General Hospital Baltimore If Under 1 Year If Under 24 Hrs. Min. North Days Hours Min. DEC 04 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F 89 218-07-7453 MD Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. fnside City Limits r then "natural", or Iteme 23s or 28s-f show The Medical Examiner must be notified at 1.□Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3006 Kenyon Avenue 21213 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer unk unk 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 end 2 should be and Mental Simon Queen Anna Mae Reddick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise Butcher/niece 1106 Walnut Ave. Baltimore MD 21229 of Health a litem 27 in 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dependent of H
Important: if ite
ony injury or ott 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ◯Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street mas 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (0 /Medical Due to (or as a consequence of) Examiner faider Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed OPD Due to (or as a consequence of) ا الاسلامان المركبة المركبة المركبة المركبة المركبة المركبة Division of Vital Records, P.O. Box 68760 Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificete hes b lirector, page 2 s autopsy 2 100 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient ဥ 2 ER/Outpatient 3□ DOA this After this funeral c 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 \ Homicide perifying Physician: To the best of my kin wiedga, death columned at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of terson who completed cause of death (Item 23a) (Type, Print) aryland Genera Monio orord 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 1 9 2006

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	r 28a	Director	10e. Street and Number				10f. Zip (Code				10g. Citizen of	What Cou	ntry?	
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Maryland 21215-0036	ntal H ed ot	Be	17. Father's Name (First, Middle William Heisch								<i>tzinge:</i>	, Maiden Sumar	ne)		
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relation			19b. Maili	ing Address	(Street a				er, City or Town,	State, Zij	o Code)	
<i>®</i>	ond 2 self h er 27 is r trau		Jill Lee Roman	/ Daug	hter							sville,			
Zre,	of Her of Her r othe		20a. Method of Disposition	2 Domoval from		. Place of Dispo cemetery, cre	osition (Name	e of her place	a)	O	ate	20c. Location	City or T	own, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. In Importment if item 21 is marked other then "naturel", or items 23a or 28a-f show any njury or other traumatic event, in Medical Examinar must be notified at once.		21. Signature of Funeral Service	Lipp	MO137	0 /2	NASI	ungco	U BIV	1., E.L	kriage, .	eadowridg MD 21075	e Memo	orial Pa	rk, IV
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	10		Dr. Russell Hillsl	ey, 3449 W	ilkens	Ave., I	Baltim	ore,	MD	21229	9				
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	· o		Decedent's Name (First, Middle, Last)					2.	Date of Death		Y <i>e</i> ar	3. Time of Death
	Physicia /Medic		Patricia Eller	r Rusche				Ju	Month LNE	13,	2006	7:10P M
	Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or				4c. County		
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	land ow		10a. State 10b. County	10	oc. City, Town or Le	ocation			-		10	d. Inside City Limits
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	r dea	nue	11. Wallar States	Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig In, Mexican	gin? (Specify i, Puerto Ric	y Yes or No- an, etc.)		e - America k, White, e	
36	s afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1□ Yes 2X No	Specify:			Specify	" whi	to
8	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23e or 28e-f show ant, the Mcdeal Exar, irretivant be rediffed at	Completed by Funeral Director	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16	Sb. Kind of Bu		
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212	giene.	E O	Elomoniary, documents (5 12)	4 Years		Grants Mar					iver	sity
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Mar	12 shoth and 7 is multiple.		19a. Informant's Name/Relationship (Typ. Jeannette Fanning			ng Address (Street)						
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nor	ages inf of t: If it		1 ☐ Burial 2 🂢 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	amoval from State	•	matory or other plac Crematory		6/15/2	2006 B	altimo	но М	aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other freumatic event, the Medical Exarchited in the rediffical at once.		21. Signature of Funeral Service License			2. Name and Addre						
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Vital		e C	25. Was case referred to medical				26. Place	of Death (C	heck only one		100	
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Division	affer death affer death Diractor:	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, si (Specify)	reet, factory, office		201	City or Town,		ei oi nurai	noute Number,
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	To tha Hospitel or within 24 hours affer To tha Funaral Dirac completely filled in E	edical	(Check only 2 Medical Examination)	ner: On the basis of ex and manner state		nvestigation, in my o	pinion, dea	th occurred	at the time, dat	e and place,	and due to	the cause(s)
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	01		30. Name and address of person who co	mpleted cause of dear		Print) OR 1	FAIL	CT	RAIT	Timas	E AL	021231
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06-04075 Cynthia M. Riley

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifica Registrar	te of Death	Reg	No. 2006 1921
Physicia	ın/	Decedent's Name (First, Middle, Last)	Riley	2. Date of Death Month D	Day Year 2114 hrs
Medical Exami			4b. City, Town, or Location of De	June 13, 20	4c. County of Death
		4a. Facility Name (if not institution, give street and number) 5726 Simmon Avenue	Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Airo.	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		212-56-5816 1 M 2XF 56	Yrs.	05 24	4 50 Country) MD
any	ŀ	Usual Residence of Decedent 10a State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits
<u>*</u>	١	MD NA Balti	imore		1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.		5726 Simmonds Ave	21215		U.S.A.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 		14. Race - American Indian, Black, White, etc.
rer dea		1 Yes XX No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Black
ours af	d by	15 Decedent's Education (Specify only highest grade completed) 16a. D	ecedent's Usual Occupation (Give kind		6b. Kind of Business/Industry
6 172 hc	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use r	etired)	Verizon
5-0036 lled within 7 Hygiene I other than	Completed	12th grade 2yrs	Operator 18 Mother's Na	me (First, Middle, Ma	
e filed tall Hyger of	ā.			Higgins	
ID 21215-003 should be filed with and Mental Hygiene 77 is marked other that it is matic event, the Med	10E		Mailing Address (Street and Number of	or Rural Route Number	
- P = E E		00.000	10 Queensgate Ro		timore, Md 21229 20c. Location - City or Town, State
<u> </u>			inv or other place)		
Baltimo permit Page Department o Important: injury or ott	-	4 Donation 5 Other Specify: WOOG 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	20 /21 /06	Baltimore Co, Md
Ba perm Depa Impe injur	ļ	23a Parql. Enter the disease, or complications that caused the death. Do not	March F/H West	a. Balti	more, Md 21215
Physician		23a Parti. Enter the disease, or complications that caused the death. Do not failule. List only one cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arres	t, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)			Death
		h			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
/	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	p		
760, ficate be executed g physician and the burial - transit	a E	d			
760, cate be exphysician	/Medical	UNPENDED 3 AMENDED 4a,20b,28f	per meo +fh g856 6	5-19-06 vt	
8760, tificate b ng physicas the bur	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pre-	gnancy	23d Date of delivery Month Day Year
Box 68' ne death certifi the attending	Physiciar	4 Pregnant at time of death 5			
b. Be the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Division of Vital Records, P.O. rate or attending Physician: The law requires that the star for death. "In Director: After this certificate has been signed by the funeral director, page 2 should be detact led in by the funeral director, page 2 should be detact.	d by			1 Yes	2 No 3 Probably 4 Unknown
rds, requir been s	Completed			24a. Was an	
eco he law ate has age 2 s	omo			perform	ed? death?
al R ian: T ertifica ctor, pi	Φ	25. Was case referred to medical	26 Place of Death (Che	ck only one)	
Vit Physical r this c	To B	1 ✓ Yes 2 No Inpatient 2 ER/Ou			esidence 6 Other: Scene w injury occurred
n of rding I h. : Afte e funer		27. Manner of Death 1 Natural 5 Pending 128a. Date of Injury Pounds Day, Year) FOUND Day, Year) FOU		Subject shot	w injury occurred
iSiO	icati	2 Accident Investigation Jun 13, 2006 2114 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.	28f. Location (Str	reet and Number or Rural Route Number, City
Div oital or urs after ral Di	Certification:	Suicide 6 Could not be determined (Specify) Single Family		5726 Simmer	rids E Avenue, Baltimore, MD
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:					
To th withir To th	Medical	2 Medical Examiner: On the basis of examination and/or if and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	2	Autz	O.C.M.E.	1	June 14, 2006
		30 Name and address of person who completed cause of death (Item 23a)			
[0]		Ana Rubio MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 212	201	
	tate	001/17 0 2000 3000	ASS.		
Regis	1161				

			For	State of Maryland				Mental Hy	giene	106	19243	
		1	- State Registrar		Cei	tificate of L	<i>Jeath</i>	2. Date of Dea	Reg. No.	700	3 Time of Death C	
	Physicia	_	1. Decedent's Name (First, Middle, Las		1	RSHOP	770	Month	Day	Year	3. Time of Death P	
	/Medic	al	MARY		1-			JUNE		y of Death	7.30	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		2(1)		imore		
L			Northwest Hospit 5. Social Security Number 6. S		ast hirthday)	Randa11		rs. 8. Date of Birt			ace (State or Foreign	
	Funeral			□ M 252F 77	Yrs.	Months Days	Hours Mi		1929	Mary.	ry)	
	Director		Usual Residence of Decedent					Tray 22	, 1,2,			
	land Now		10a. Slate 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits	
:	Mar.	tor	Maryland Baltim	ore C	atonsv	ille					1 ☐ Yes 2 ☒ No	
	7.28	Director	10e. Streel and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
	23a (1) Wi	ai	6123 Wheatland			2122			USA			
	ems ems	Funerai	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Ha	ice - America ack, White, e		
2	or it	Ž F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔣 No		1 ☐ Yes 21 No	Specify:		Spec	ify:	White	
Ś	urai.	Completed by	15. Decedent's Ed	Year or Dates:	16a Dece	deni's Usual Occupa	ation		16b. Kind of	Business/Ind	lustry	
5	n 72	jete	(Specify only highest gra	ade completed)	(Give	kind of work done of DO NOT use retired	furing most of w	vorking			,	
7	the the	E	Elementary/Secondary (0-12)	College (1-4or 5+)	S	upervisor			C & F	Tele	phone Comp.	
ט ס	should be filed within 72 hours after deeth with the Marylan of Memiel Hygiene. Tarked other then "natural", or items 23a or 28a-1 ehow marked other then "natural", or items 23a or 28a-1 ehow marked other then "natural".	Be C	17. Father's Name (First, Middle, Last,)			18. Mother's N	lame (First, Middle,	Maiden Suma	ıme)		
a	id be entel ked c	To B	Wilbert Rittersh	ofer			Mary A	. Glennon				
	should be filed within 72 hours atter deeth with the Maryland and Mentylene. I marked other then "natural", or items 23a or 28a-f ehow unatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or	Rural Route Numbe	er, City or Town	n, State, Zip	Code)	
Ξ	elth a elth a 27 tr		Joan G. Shyposh	Cousin	29 Cc	lony Driv	re: Sumr	nit, New	Jersey	0790		
ē.	of He item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		lace of Dispo emetery, crea	osition (Name of matory or other place		Date		•		
Ĕ	Pege Int: H		4 □Donation 5 □ Other (Special			e Cemeter		4/2006				
Baitimore, Maryland 21213-0030	permit. Peges 1 and 2 should be Department of Heelth and Mente Important: If item 27 is marked eny injury or other traumatic events.		21. Signalure of Funeral Service Lice	nsee	2: F	2. Name and Address Suneral Ho 630 Edmon	ss of Facility Stome of (terling A Catonsvil Venue: Ca	shton S le, Inc tonsvil	chwab le. M	Witzke D 21228	
			23a. Part1. Enter the disease, or com-	plications that caused the deatl	h. Do not en	ter the mode of dyin	g, such as card	liac or respiratory a	rest,		Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final			moni	A				Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		,						
	Examiner			CA	VCF	ROF	THE	Lur	VGS	or Town, State, Zip Code) Sey 07901 .ocation - City or Town, State 1timore, MD on Schwab Witzke Inc. Sville, MD 21228 Approximate Inlerval Between Onset and Death		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence								
	oute ransii	Examiner	that initiated events	c								
ó	ie be executed ysiclen and ie burial-transit	EX	resulting in death) Last	Due to (or as a consequence	uence of):							
3760,	icate be executed physicien and s the burial-transit	ical	•	d								
89	The law requires thet the death certificate is the best been signed by the ettending physinges 2 should be detached for use as the t	Physician/Medi	IF FEMALE:									
Box	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta	I death 3	☐Ectopic pregnancy ☐ Other (specify)						
-	the e	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown	Healii 51	Other (specify)						
0.	thet the de ed by the detached	P.	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?	
ds,	ilres the signed d be del	d b						i x	Yes 2□No	3 🔲 Prob	ably 4 Unknown	
Ö	w requir been si should	Completed						24a. Was	an 24t	. Were aulo	psy findings available	
ĕ	hes hes	E D						_ auto		prior to cor death?	npletion of cause of	
<u></u>	n: The lifeate he		os tita and added				Of Diese of C	1 ☐ Yes Death Check only o		1 U Yes	2V No	
of Vital Records,	Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpatient 2	ER/Outpatie	int 3□ DOA Oth	oc	g Home 5 ☐ Resi		ther (Specifi	v)	
ō	Phys r this ral dii	To	27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injur	y al	28d. Describe			<u>"</u>	
Division	ding th. Th.	tion	Natural 5 Pending investigation	(Month, Day Year)	Injury	M 1	k? Yes 2 ☐ No					
isi	Attender dead	fica	3 Suicide 6 Could not	286. Place of injury - Al In		treet, factory, office		28f. Location (City or To		nber or Rura	l Route Number,	
á	al or Attendir s efter death. of Director: Al	Certification:	4 Homicide	building, etc. (Specif	(y)			Only or 10	,, 5,4,5,			
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer	Medical C	29a. Certifier Check only one) Certifying P	Physician: To the best of my known arminer: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the time	me, date and playinion, death o	ace, and due to the courred at the time,	cause(s) and date and place	manner as si	ated. the cause(s)	
	ithin o the omple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
	F 3 F 8		1901.0990	Years 1	MD	DU	LILL 2 .		Tinn	C 14	+TH-DANK	
	1		30. Name and address of person who	completed cause of death (Itel	m 23a) (Tvna	, Print)	1730			C 1"	1 2006	
	5		DR. OBAZE	= EDWARD	N1-	W. HOSF	TAL	RANDA	LLST	OWN	MD 2//3	
	S	ate	31. Date filed (Month, Day, Year)	completed cause of death (Iter	ature	160						
	Regis		JUN 1 9 200	6 Server St.	Spe							

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19244

		For State	Certific	cate of Death	1		Reg. No.	2000	1024
Physician/	1.	Decedent's Name (First, Middle,Last)	0 /			2. Date of De Month	Day	Voor	Time of Death 1450 hrs
Medical Examiner		MEIVA . V.	RUMEL	4b City To	own, or Location of	June 10,		unty of Death	1400 1113
	48	Facility Name (if not institution, give stre 2910 McElderry Street	at and number)	Baltim			10. 00.	NIA	
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Unde Months		Min	•	YYYY) 9. Birthpl Foreign	4 .
Director	å	16-42-2147 1 M	2 F 65	Yrs.	Bayo	June	29,19	140 Count	y) MD
any	_	sual Residence of Decedent a. State 10b. County	10c. City, Tow	n or Location	1			10	d. Inside City Limits
		MD NA		BALT	More			1	Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10	De. Street and Number		10f. Zip	Code			of What Country	?
h the N 3a or sotifies	L	<u> </u>	lerry. ST.	Tio W P	21205	0 (0 //		S.A. Race - American	a tadion Plank
or items 23a or 28a-f shormust be notified at once. Funeral Director	1 1	. Marital Status 12. Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?			gin? (Specify Yes or N , Puerto Rican, etc.)		White, etc.	i ilidian, biack,
	1 3	Widowed 4 Divorced If Ye	Yes 2 No s, Give Year	1 Yes 2	No specify:		Spe	ecify: whi	Te
ours aft		15. Decedent's Education (Specify only hi		a. Decedent's Usual during most of wor			16b. Kind	of Business/Indi	ustry
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		Elementary/Secondary (0-12)	College (1-4 or 5+)	1100	enaker		or	on Ho	me
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica Be Comple	1	7. Father's Name (First, Middle, Last)	,0 (4	ITUIN		's Name (First, Middle	, Maiden Sur	name)	
215 be file mal H- rked or rked o	: [Melvin Westerf	iels				nkno		
b 21215-00; should be filed with and Mental Hygiene 7 is marked other the natic event, the Meron To Be Com	1	9a. Informant's Name/Relationship (Type,				nber or Rural Route N ey ST. B			and the same of th
ore, MD 21215-0036 s. I and 2 should be filed within 77 of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medical To Be Comple	1/2	HERMAN RUM Oa. Method of Disposition	20b. Place	e of Disposition (Nar	ne of cemetery,	Date Date		ation - City or To	
nore ges I s rt of H i: If if	1-2		(emoval from State)	natory or other place)		6/14/06	BA	Ito-Mi	,
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 injury or other traun	2	Donation 5 Other Specify: 1 In nature of Funeral Service Licensee	1 0012	22. Name and	Address of Facilit		re PA	010 1	<u> </u>
Per Per Initial	1	faul M.	Stells	7527 h	aferil 1	SinceAl Holes. Balto.	NO 2	1234	
Physician Medical	2	3a. Part I. Enter the disease, or complicat failure. List only one cause on each li	ne.		of d yi ng, such as o	cardiac or respiratory	irrest, shock,	or neart	Approximate Interval Between Onset and Death
Examiner			erosclerotic Cardiovaso to (or as a consequence of):	cular Disease					- Doda
		Sequentially list conditions, b							
iner	į	fany, leading to immediate Due ause. Enter Underlying Cause	to (or as a consequence of):						
red Insit	1 1 2 3 3 3 3 3 3 3 3 3 3	Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):						
760, aate be executed physician and he burial - transit	5	dd	MENDED						
760, icate be execut the burial - tra			3c. If yes, outcome of pregnan	су			23d. D	ate of delivery	
		Bb. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal death		ic pregnancy	Mo	onth Day	y Year
X 4 4 5 1 7	2	1 Yes 2 ✓ No 9 Unknown	death	5 Other (Spe	ecify)				
O. Bc at the dea I by the a trached fo		Part II. Other significant conditions con	ntributing to death but not resul	Iting in the underlying	g cause given in P				e cause of death?
ords, P.O. w requires that the as been signed by to should be detache	2					- 1			psy findings available
Records, The law required ficate has been sign, page 2 should be							topsy rformed?		mpletion of cause of
Recc The lav icate har	5					1 Ye	s 2 🗸 N	1 Yes	2 No
Vital Rec ysician: The his certificate director, page	os l⊟	25. Was case referred to medical examiner?	pital:		26.Place of Death	(Check only one) Nursing Home 5	Pasidence	e 6 🗸 Other: S	Scene
ing Physician: The law requiring Physician: The law requiring Physician in the law requiring Physician in the law requiring Physician Ph		1 Yes 2 No	28a. Date of Injury 28	R/Outpatient 3 [Bb. Time of Injury	28c. Injury at Wor		e how injury		-
on of value Phath. or: After the funeral		1 Natural 5 Pending	(Month, Day,Year)		1 Yes 2	No No			
Division o spiral or Attending tours after death. neral Director: After the filled in by the function.	<u> </u>	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e, farm, street, factor	y, office building, e		n (Street and n, State)	Number or Rura	Route Number, City
Divi	5	4 Homicide determined	(Specify)						
		one) 2 Medical Examiner:Or	To the best of my knowledge, the basis of examination and/	death occurred at th or investigation, in m	e time, date and p ly opinion, death c	lace, and due to the concourred at the time, d	ause(s) and nate	nanner as started , and due to the	a. cause(s)
To t with To t	Medical		d manner stated.		c. License numbe			te signed (Monti	
		Tal uso	AQ.		O.C.M.E.		June 1	12, 2006	
0/		30. Name and address of person who com			at Delle-	MD 04004			
V			nt Medical Examiner 32 Registrar's Signature	111 Penn Stre	et, Baitimore,	IVID 21201			·
Stat Registra	te ar	JUN 1 9 2006	Laura A	(DONE)			<u>-</u>		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2 /Medical ogers May 2006 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Laurel Hearth G aurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 228-14-2029 Months Director Usual Residence of Decedent deeth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner invist be notified at once. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits P.G. MD Director Laurel 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. 20724 Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Å Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No <u>م</u> White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5tink LAborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmett Rogers Mary Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra George/ niece 10 N. Betty St. Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) In state 21. Signatur of Funeral Servic Licenses State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 25a. Part \Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 6 mould Examiner Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificete be executed attending physician and I for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 be detech Morres ohi 1 X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown cete has been signated; 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? this certificete has 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4SNursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYEN 5/6 Dowie 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JUN 1 9 2006

			1 - For State Registrar	State of Man		artment rtificate			and M		giene Reg. No.	2006	1924	5
	Physici	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of De Month	ath 18	2006	3. Time of Death	
	/Medic	al	Patricia Rodhe	in stead and sumber		4h City	Town or	Location o	d Death	May		County of Deal		_
۲	Examin	er	4a. Facility Name (If not institution, ga Washington Advent		1	Tocom			Doam			lontgom		
	Funeral Director		5. Social Security Number 6. 261–60–6606		n yrs. last birthday, 65 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov 22	th 194(9. Bin Cc	hplace (State or Foreign ountry) PA	7
	Maryland f ehow	٥٢	Usual Residence of Decedent 10a. State 10b. County Montage		oc. City, Town or L								10d. Inside City Limits	
	r 28a-	Director	MD Montgo	omery	Tacoma 1	10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	th with	aiD	4913 Hollywood	Road		207					USA			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or items 23a or 28a-f ehow important: if Item 27 ie marked other than "natural", or items 23a or 28a-f ehow applying or other traumatic event, the Medical Examinar must be multified at once.	by Funerai	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)) -	14. Race - Ame Black, Whit Specify: W		
Baltimore, Maryland 21215-0036	vithin 72 ho ne. hsn "natur e Medical i	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Ĝive life.	edent's Usua e kind of wor DO NOT us Iomema	rk done d se retired	luring most	t of workir	ng		nd of Business	Industry	
and 21	d be filed wental Hygier to	To Be Co	12 17. Father's Name (First, Middle, Later) John Edward Ever			iomema				(First, Middle Cather	, Maiden		star	
Mary	nd 2 shoul lith and M 27 le marl r traumati	-	19a. informant's Name/Relationship Kenneth Rodhe/	(Type, Print)	19b. Mail 4913	ing Address Ho11y	(Street a	nd Numbe	or or Rura Co11	Route Numb	er, City o rk M	r Town, State, . D 20740	Zip Code)	
more,	Pages 1 and neut of Head int: If Item irry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	1	20b. Place of Disp cemetery, cre	osition (Nan matory or o	ne of ther plac	θ)	D	ate	20c. Lo	cation - City or	Town, State	
Balti	permit. Depertrainmports eny inju			- These	St Ba	altime	nato	my Bo MD 21	ard 1201			timore	Street	
È	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	SPIRA	nter the mod					rrest,		Approximate Interval Between Onset and Death	
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	1E 8				7 F	Accol	LE			_
8760,	wrequires thet the death certificate be executed been signed by the ettending physicien and should be detached for use as the buriat-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence of):		kto (R	-					
P.O. Box 68	The law requires thet the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pr □ Other (sp						23d. Date ol de Month	livery Day Year	
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Division of Vital Records,	The lar	Completed		Borenia					_	24a. Was auto perfe 1 \(\text{Yes}		prior to death?	utopsy lindings available completion of cause of 2 No	,
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	90		(Check only	· · · · · · · · · · · · · · · · · · ·			_
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Division	ol or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 290 Place of Injuni		treet, factor				281. Location (City or To			ural Route Number,	_
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	St Regist	ate	31. Date filed (Month, Day, Year)	no completed cause of dea	s Signature	Pos	K)		1116	- 10, D. P.	1000	, ,	,	

			For State Registrar	State of Ma	arylan		artment <i>tificate</i>			and Me		jiene leg. No.	006	19247	1
I.	Physici	an l	1. Decedent's Name (First, Middle, Las	t)						1	2. Date of Dea Month	th Day	Year	3. Time of Death	
	/Medic		James Riggi								June	15,		2:45 PM	A
	Examin	er	4a. Facility Name (If not institution, give		_		4b. City, To			f Death			County of Death		
14	- Sec		Stella Maris 5. Social Security Number 6. Se	Hospice		last birthday)	Timo		If Under:	24 Hrs. 8	8. Date of Birth		altimo		
	Funeral Director			XM 2□F	70	Yrs.		Days	Hours		(Month, Day ug. 18,	1935	West	place (State or Foreig ntry) Virginia	,,
	9		Usual Residence of Decedent												_
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	ne 23	Funeral Director	11. Marital Status	12 Was Decedent	Ever in U.	.S. 13.1				gin? (Spec	offy Yes or No- lican, etc.)		4. Race - Ameri		_
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lar	should be nd Mentat marked o	To B	Percy Daniel						Glad	ys Le	ona Re	ese			
ar)	2 sho and 1 is ma		19a. Informant's Name/Relationship (7				_					-	Town, State, Zi		
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Baltimore, Maryland	permit. Pages 1 and 2 should by Department of Heath and Menta Important: If item 27 is marked any njury or other traumatic evonce.		20a. Method of Disposition 1 Aburial 2 ☐ Cremation 3 ☐		C	Place of Dispo emetery, cren	natory or oth	er place					ation - City or T		
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JUNE 15, 2006

JAMES RIGGINS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** DOROTHEA ELIZABETH ROSS 9_ JUNE 2006 6:40AM /Medical 4a. Facility Name (II not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FUTURECARE-CHARLES VILLAGE BALTIMORE N/A CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 1 □ M 2 🖫 F Yrs. 219-10-9824 83 03/04/1923 MARÝLAND Director Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits I show rthan "naturel", or itama 23a or 28a-f shovine Medical Examiner must be notified at XXYes 2□No MD N/ADirector BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2752 WINCHESTER STREET 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if item 27 is marked other than ury or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event. HOUSEKEEPER DOMESTIC 10TH 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be HARRY EDWARD JOHNSON SADIE ALYOTTE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. JACOBS/DAUGHTER 2752 WINCHESTER ST., BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of t
important: if ite
any injury or of XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PK. 6/15/06 BALTIMORE CO., MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 of the disease, or complications that caused the death. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death so not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Yuse (Final **Physician** monto /Medical resulting in death) Due to (or as a consequence of): Examiner resturon Sequentially list conditions, I am, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or 35 a consequence of) Examiner the death certificate be executed Da bely tran and resulting in death) Last Due to (or as a consequence of): the ettending physicien a thed for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the e d be detached f 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificete 1 Yes 2 No 1 Yes 2 No Division of Vital ours efter death.

nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 🖓 0 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours effer or To the Funeral Directions 4 Thomicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Than Bon, mid, FAEP D51088 JUNE 15, 2006 30. Name and address of own on who completed cause of peath (Item 23a) (Type, Print) Thow Poon Bullimoy, mb 21202 taml #707 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Box 68760,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month James Bernard Sullivan 2006 June 17, 9:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerford Place Columbia Howard ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F 213-03-3314 90 Director 12/18/ 1915 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f show tra Medical Examinar must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 → No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Winstead Court 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Bfack, White, etc. 17 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) Health and Safety Koppers Company 8 s 1 and 2 should be filed v f Health and Mental Hygie Itam 27 is marked other t other traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Bernard Sullivan Sr. Elsie M. Diven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2
ment of Health at nt: If Item 27 is 1 5 Winstead Court, Catonsville, MD 21228 Phyllis Morris Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 06/22/2006 Elkridge, MD 21. Signature of Foneral Service Licer cary L. Kaumen Fureral Home at Meadowridge Memorial Park, INC. M01378 7250 Washington Blvd., Elkridge, M and Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. 7250 Washington Blvd., Elkridge, MD 21075 Interval Between Onset and Death Inmediate Cause (Finaf disease or condition resulting in death) Cinterroscle **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No igned by the atte be detached for Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes : After this certific s funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2×10 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doff m. D.

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31. Date filed Morry, Cay, Fear 116

				partment of Health and Me ertificate of Death	ental Hygien	4000	19250
	Obvojoj		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Yeer	3. Time of Death
	Physici /Medic		Mary Emily Smitzel		June 16,	2006	7:02 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Deat	
			Glen Meadows 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Glen Arm If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	nplace (State or Foreign
	Funeral Director		220-38-8674 1 M 2 X F 99 Yrs.	Months Days Hours Min.	Month, Day, Year Dec. 6, 1.9	') Co	vland
	D		Usual Residence of Decedent		DCC. 0,3	700 Hai	yruna
	arylan show		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
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	with the	Funeral Director	10c. Street and Number	10f. Zip Code	10g. C	itizen of What Co	untry?
	s 33	eral	11630 G1en Arm Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	21057 3. Was Decedent of Hispanic Origin? (Spec	ify Yes or No-	U.S.A.	rican Indian
' 0	r Iten	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White	
Ö	rel', o	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ X No <i>Specify:</i>		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "naturel", or Items 23e or 28e-1 show event, the Medical Exertiting or until be multipled at	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation we kind of work done during most of working	16b. I	Kind of Business/	ndustry
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7	filed v Hygie ther t	ပ္ပ	9 H		(First, Middle, Maide		<u> </u>
Maryland	id be ked o	To Be	William Franklin Meade	Carrie	Lewis		
ary	should and Men s marke umatic	-		iling Address (Street and Number or Rural		or Town, State, Z	ip Code)
	as 1 and 2 of Health a fitem 27 ls r other tree		Peggy Mahoney DAUGHTER 340	1 Greenway Baltimo	ore, Maryl	and 212	218
ore	of He of He If iten		20a. Method of Disposition 1¥☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Competery. C. Cardens	position (Name of Parametery or other place) OT Faith	ite 20c. l	ocation - City or	Town, State
Ë	. Pages tment of l tant: If it jury or o		Donation 5 Other (Specify)	Cemetery 6-19-2			Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatily and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 32e or 28e-1 show amortant: in item 27 is marked other than "naturel", or items 32e or 28e-1 show amount injury or other treumatic event, the Mardical Examination, and by multible at ODEs.			22. Name and Address of Facility Ruck 1050 YORK ROAD TO	k Towson F DWSON, MAR		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cerdiac or	respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		Due to (or as a consequence of):	1			9
В		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury				
Ó	exect an and rial-tra	Еха	resulting in death) Last C. Due to (or as a consequence of):				
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9	ertifica ing ph e as th	Physician/Med	IF FEMALE:				
Вох	leath certifi attending I I for use as	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of deli- Month	very Day Year
P.O.	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	□ Other (specify)			,
	n requires that the death been signed by the atte should be detached for		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
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00	aw req as beer 2 shou	olete	My set ensian		24a. Was an	24b. Were aut	topsy findings available
Be	The lav te has age 2	Completed by	Ji		autopsy performed?		ompletion of cause of 2 □ No
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of V	hysic his ce Il dire	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		e 5 Residence	6 Other (Spec	1-21 21 -
Ē	Attending Physiclen: r death. sctor: After this certifics by the funeral director.	ion:	27. Manner of Death 1 ☑Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	3d. Describe how inju	iry occurred	
isio	ttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	If. Location (Street a	nd Number or Ru	ral Route Number
Division	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	Silest, factory, office	City or Town, Stat		ar noble Number,
_	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, ar	nd due to the cause(s	and manner as	stated.
	n 24 h	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d at the time, date an	d place, and due	to the cause(s)
	To ti To ti comp	Ě	29b. Signature and title of certifier	29c. License number		ite signed (Month	
			· /w/ day	D30433	Jui	VE 16, 2	2006
	10		30. Name and address of person who completed cause of death (Item 23a) (Type CFM C 670 I N C	B. Print) HARLET ST SHE	TUI	MO.	21204
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registi	ar	JUN 1 9 2006 Region 18	one (i)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year Julius 07:45AN 2006 may 11 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2824 Rosalie Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 30 1910 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F 218-18-4758 95 Yrs. Director Poland Poland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or Itams 23a or 28a-f shov the Medical Examinat must be notified at 1,□Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2824 Rosalie Avenue 21234 Be Completed by Funeral USA Pages 1 and 2 should be filed within 72 hours after death nent of Heatith and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23 arry or other traumatic event, the Medical Examinations! 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Wmar College (1-4or 5+) TV technician unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simon Thiel Eugenia Demky ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Theil/son 2 Bargate Ct. Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Dep riment of Important: If any njury or once. 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Mon Baltimore, Md 21201 23a. Parl 1. Enter the is ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Opset and Death Cardimyopathy Immediate Cause (Final disease or condition resulting in death) **Physician** Lyears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Isabin 13 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 2 X No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29c. License number 2 Watertield 024356 9103 Frontin Boltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no In C WATERFIELD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elesus & Sperk Registrar JUN 1 9 2006

06-04023 Jon Trudel Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Sir riodo.	R	- For State Control of Maryland / Department / Department	Re	eg. No.	200	06 1925
Physician	1	1. Decedent's Name (First, Middle,Last)	Date of Dear Month	Day	Year	3. Time of Death
Medical Examine		Jon R. Trudel	June 12, 2	2006		0022 hrs
gar the	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 45820 Highway to Heaven Lane Great Mills			t. Mary's	1
	4		O Date of Ric			thplace (State or
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	-		Foreig	n
Director	L	287-56-2694 1XM 2F 45 Yrs.	May 1	9, 1	.961	untry) Ohio
any	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County	-			10d. Inside City Limits
\$						1 Yes 2 X No
Maryland 28a-f show datonce.		Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code		0a. Citiz	zen of What Cou	ntrv?
the Maryland a or 28a-f sh lifted at one	<u> </u>					
		45860 Highway to Heaven Lane 20634 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp			ed Stat	es ican Indian, Black,
or items 23	<u> </u>	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto			White, etc.	
rer de		1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1981 – 1991 1 Yes 2 X No specify:		1	Specify: Wh	ite
urs af trural amin	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		16b. K	(ind of Business/	industry
72 ho n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired to the control of the control	rea)			
036 rithin rear tha	림	12 Avionics Engineer				overnment
15-0036 filed within I Hygiene. I do other that it the Medic		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, I	Maiden	Surname)	
21215-0036 build be filed within 7 Mental Hygiene. marked other than te event, the Medica	å		Geari			
Should and M matic e	۱ ۵	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			•	
≥ pd de m	ŀ	John L. Trudel/Father 554 Cardinal Drive, A	Archbolo Date	U و 120c.1	Location - City or	OUZ Town, State
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Mont gome ry Jui	ne 14,			
t. Pag tmend tment rtant:		4 Donation 5 Other Specify: 21. Signature: Funeral Service Licensee Montgomery Crematorium, Inc. 22. Name and Address of Facility Rot	06	Be	thesda,	Maryland
Baltimord permit. Pages I Department of I Important: If injury or other	-	4 Donation 5 Other Specify: Crematorium. Inc. 200 21. Signature: Funeral Service icensee M00803 Rockville, Inc. 30 Rockville, Maryland	0 West	Mon	tgomery	Avenue
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	r respiratory arr	est, sho	ock, or heart	Approximate Interval
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a Gastrointestinal hemorrhage complicating hypertensive cardic	vascular di	sease		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal hemorrhage complicating hypertensive cardic pue to (or as a consequence of):				
		Sequentially list conditions, b				
	듸	if any, leading to immediate cause. Enter Underlying Cause Cleanes or light that is litted.				
	Xal	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ᄥ	d		-		
760, cate be ex physician he burial	Medical	UNPENDED				<u> </u>
760, ficate be g physici the bur		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	incv	230	 Date of deliver Month 	y Day Year
Sox 687 leath certific e attending	Sal	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnat 4 Pregnant at time of death 5 Other (Specify)				
Box 68 e death certificate attending ed for use as	Physician	1 Yes 2 No 9 Unknown g Unknown				
P.O. es that the igned by i be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			-	the cause of death?
s, P.C iires that i signed d be deti	a p	chronic alcoholism				bably 4 🗹 Unknown
ords			24a. Was autor	osy	prior to	utopsy findings available completion of cause of
he law ate has age 2 s	Completed		1 Yes	rmed? 2 N	death?	es 2 No
tal Rection: The certificate ector, page	o l	25. Was case referred to medical 26.Place of Death (Check	only one)			
Vit.	8 2	1 V Yes 2 No	g Home 5		ence 6 🗸 Othe	er: Scene
n of ing Pt After funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 Panding	28d. Describe	how inju	ury occurred	
ior ttend death ctor:	<u>≝</u>	2 Accident Investigation				
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been silled in by the funeral director, page 2 should be the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,		ind Number of R	ural Route Number, City
pspita hours meral		4 Homicide	<u> </u>	4.)		
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	ica	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a				
To t Com	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. I	Date signed (Mo	onth, Day, Year)
		O.C.M.E.		Jun	e 15, 2006	
- x1		30. Name and address of person who completed cause of death (Item 23a)			_	
13		Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201			
Sta	ite	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	1			
Registr	ar	JUN 1 9 2006 Heave & Sparker				

				1- State Amend Item	State of M n 29d pe	aryland/l r Dr.,	Departme G856 (Certifica	nt of L	lealth an Death	d Mental Hyd b	giene	006	19253
		1		1. Decedent's Name (First, Middle, Last						2. Date of Dea	ath		3. Time of Death
		Physic /Medi		Rosario Vinc	ent Tambu	ro				Month Tu~	e 13	2006	935 pm
	×	Exami		4a. Facility Name (If not institution, give		0 1 1	4b. Ci	ity, Town, o	r Location of D	eath		ty of Death	
				Sinai Hospito		Baltin		salti	mare	city	n/a		
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		and II		10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside City Limits
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		death with the Maryland me 23a or 28a-f show Findst be notified at	Director	10e. Street and Number		DOT CTING		y Zip Code			10g. Citizen of	What Count	
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G		deat	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.			ispanic Origin	(Specify Yes or No- uerto Rican, etc.)	14. Ra	ice - America	
1	9	or Ite	교	1 X Never Married 2 ☐ Married	Armed Forces? 1 ⊠Yes 2 ☐ I If Yes, Give					Jerto Hican, etc.)		ack, White, e	
OSOL	8	ure!',	d by	3 Widowed 4 Divorced	Year or Dates:			2 X No	Specify:		Speci	⁄፦ Whit	ce
0	21215-0036	within 72 hours after ene. then "naturel", or Ite ne Medical Evanifie	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Decedent's U: (Give kind of the life. DO NOT	work done o	during most of	working	16b. Kind of B	Business/Indi	ustry
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_		illed Hygid other	BeC	17. Father's Name (First, Middle, Last)			, 00 001	WOI K		Name (First, Middle,			Service
0	Maryland	lid be fental rked c	To B	Joseph Tamburo					Josep	hine Glos	rioso	,	
Š	ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship (T)	ype, Print)	196	Mailing Addre	ess (Street a		Rural Route Number		, State, Zip (Code)
7		is 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene. Item 27 is marked other than "nature!, or iteme 23a or 28a-f show other traumatic event, the Medical Evantimer must be notified at		Mrs. Mary Paynter/	/sister	7	'08 Camb	perly	Circle	, Towson,	Maryla	nd 21	204
. 3	altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of	Disposition (A	lame of			20c. Location		
10	Ē	Pag ment tant:		4 □ Donation 5 □ Other (Specify)		New Ca	thedra:	l Ceme	etery	06/19/06	Balt	imore.	MD
1	Ball	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is eny injury or other trau		21. Signature of Funeral Service Licens					ss of Facility	Ruck Tows	on Fun	eral H	łome, Inc.
		40200	-		téphen Cos					Towson Mar		21204	
	J			23a. Part f. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final	ne cause on each lir	ne.	not enter the m	ode of dying	g, such as card	liac or respiratory arr	est,		Approximate interval Between Onset and Death
•)	Physician / /Medical		disease or condition resulting in death)		mos		01					2 days
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#	0	t the de by the tached	hysi	9 Unknown	9□ Unknown			Specify					
11	S, P	as tha	by Physician/Me	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting in	the underlying	cause give	n in Part I.	23e. Did tot	acco use con	tribute to the	cause of death?
	Division of Vital Records,	w require been sig should t								_ 1 □ Y€	s 2 No	3 Probab	oly 4 Dunknown
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	ot	Phys this ral dir	<u>۲</u>	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Minpatie				4 LI Nursing	Home 5 Reside			
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	İSİ	i or Attendi after death. Director: A i in by the fu	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, far				28f. Location (St	reet and Numb	er or Rural F	Route Number
	á	in the	Certification:	4 Homicide	building, etc	: (Specify)		,,		City or Town	, State)		iodio (vambo),
		Hos Fun Fun tely	edicai (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and	death occurre Vor investigatio	d at the time	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	use(s) and ma	inner as state and due to th	ed.
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) Lankara-	ni MI)		RES	5 - 90	0			
		X		30. Name and address of person who co		eath (Item 23a) (Type, Print)				<u> </u>		2006
				ALI LANKAR	LANI,	MD	Siv	noni	4086	ital of	13	ontein	MOre
		Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	le			J			

06-03952

Please Type or Print in Black Indelible Ink William Woodcock State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 9, 2006 1042 hrs Examiner William Woodcock 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6682 Montgomery Road Elkridge Howard 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In yrs. last birthday) Foreign Country Maryland Days Hours Director 214-48-0487 01/07/1946 1X M 2 F 60 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Elkridge 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho antit fitten than the Medistal Examiner must be notified at once. MD Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6284 Montgomery Road 21075 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Widowed f Yes, Give Yea Yes 2X No specify: 4 X Divorced Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Consultant Self Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William J. Woodcock Helen Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Woodcock, JR Son 6127 Orient Lane, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) rtment c Meadowridge Memorial Park, INC 06/17/06 Elkridge, MD Donation 5 Other Specify: 21. Signature of Juneral Service Licensee 2 Name and Address of Facility L. Kaulinan Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 M01378 230. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval /sician failure. List only one cause on each line. Between Onset and Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical \overline{X} AMENDED 23a,27 per me g857 7-3-06 vt// X UNPENDED item#4a,perME,g857,7/7V06 TT attending physician for use as the burial Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 Nο 1 Yes o the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other₄ DΩA ER/Outpatient 3 Inpatient 2 Nursing Home 5 ___ Residence 6 ✔ Other: Scene 1 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 24 To the F 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 111 Penn Street, Baltimore, MD 21201

State Registra

32 Registrar's Signal

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		1 - State	State of Maryland	Department of Health a Certificate of Death		
	W. att.	Registrar 1. Decedent's Name (First, Middle, Las	st)	Certificate of Death	2. Date of Death	. No.
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	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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7 0 80 = 5		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ntery, crematory or other place)		
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Physician		shock, or heart failure. List only of	one caus An each line.	m - 1 - 1	. /	Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene 🤈 For Amend Items 23a, 24a, b, 25, 26, 27, 1962 at 200, 96/19/06dhb Requisiter Amend Items 23a, 24a, b, 25, 26, 27, 1962 at 200, 96/19/06dhb 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 0510 CLIFFORD WILLIAMS 26/ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Months | Days | Hours | Min. | 8. Only | HOLY CROSS HOSPIFAL HONTGOMERY 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 MM 2□ F Months O'S 86 262-18-2106 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 9101 USA 2 COND ANE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Exampla unk 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FOREST GLEN RD SILVER SPRING MD 20910 HOLY CROSS HOSPITIAL 1200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 22. Name and Address of Facility 21. Signature of Funeral Service Licensee State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Ronald S won Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Hemmorrhagic Stroke Immediate Cause (Final BRAIN **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Hypotension Sequentially list conditions, if any, leaving to innediate cause. Enter Underlying Cause (Disease or injury Dualto (or se a consequence of) Examiner The law requires that the death certificate be executed years Diabetes and that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the attending physicien years Multi Infarction Dementia by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No datached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🏋 No has funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? I or Attending Fafter death. Division 5 Pending investigation after death. 1 □ Yes 2 □ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide within 24 hours a To the Funeral L Hospital tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sign furth and title of certifier 29c. License number D50987 HAMED NAMAY 05-30-06 83819 Gailhersburg m0 20883. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX AHMED NAWAZ 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 9 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1 27 AM WILL LAUREN മയം June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) April 7, 2004 toplans 141 MOL 7. Age (In yls. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 XF Months 2 Director 216-69-1579 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State il Hygiene. . other then "neture!", or llema 23a or 28e-f ehow vent, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Lutherville Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Solway Road 21093 USA Pages 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene.
ant: If Item 27 ie marked other then "neturet", or Itema 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 0 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jefferson Christine E. Fields Τ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Christine Will/Mother 211 Solway Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Dulaney Valley Mem. Grd. 6/19/06 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensie 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or confdications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10mpe Physician 26 months sease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Lîve birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 225 No 3 ☐ Probably 4 ☐ Unknown neumococca 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1⊠ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760. P.O. I Division of Vital Records,

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier - 8

29c. License number RES-000 MD

St.

Baltimore

29d, Date signed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McCabe 600 MO N

31. Date filed (Month, Day, Year) JUN 1 9 2006 32. Repishar's Signature

State

Registrar

		•	For State Registrar	of Ma	ryland / Depa <i>Ce</i> a	artment of rtificate of		d Mental H	ygien Reg. N	4000	19258
			Decedent's Name (First, Middle, Last)					2. Date of D	D	ay Yeer	3. Time of Death
	Physicia /Medic		Charles Kelley Yost					JUN		13 2006	121 09 PM
	Examin		ta. Facility Name (If not institution, give street and n	umber)		Ball	or Location of D			c. County of Death	
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	p.		Usual Residence of Decedent		10c. City, Town or Lo	eation					10d. Inside City Limits
	anylar show	5	10a. State 10b. County		•	cation					1 X Yes 2 □ No
	with the Maryland a or 28a-f show be notified at	Directo	faryland 10e. Street and Number		Baltimore	10f. Zip Code			10a. C	Citizen of What Co	intry?
	with with the party	ā	849 Glen Allen Drive				229			USA	,
	ter death Iteme 23	Funeral	11 Marital Status 12. Was De		ver in U.S. 13.			? (Specify Yes or found of Puerto Rican, etc.)	No-	14. Race - Amer Black, White	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other then "natural", or Iteme 23e or 28e-f show umatic event, the Modical Exertiner must be notified at	by Fur	If Yes. C	2 🗆 No	0	1 ☐ Yes 2 🙀 No		dello ricali, etc.)		Specify: wh	
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IZ a	thould id Men marke matic	2	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Stree		Elizabeth or Rural Route Num		or Town, State, Z	ip Code)
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74 2 1		30. Name and address of person who o	completed cause of	death (Item 23a) (Type	, Print)	^	\ I	1 %	1 . 1 3.5
nes		William Lamin	m.D.	100 Seto	n Urive	, Cum	voerland	a, Mary	1 and 61502
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		1	1 - For State of Maryland / Department / Department / Depa	artment of Health and Me tificate of Death		ene 006	19260
12		76	Decedent's Name (First, Middle, Last)	2	. Date of Death	Dan Vara	3. Time of Death
	Physicia		Evelyn Margaret Ault		Month June	8 2006	1:00 P.M
3. 1 28	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
7	- Examini		Garrett Memorial Hospital	0akland		Garrett	
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	ne 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		14. Race - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show amply injury or other treumatic event, I've Madical Examinar motal be notified at ODE.	by Funeral	1 Never Married 2 N Married 1 Tyes 2 N No	if Yes, specify Cuban, Mexican, Puerto Hi 1 ☐ Yes 2 🎇 No <i>Specify:</i>	can, etc.)	Specify: White, white,	
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שַ	othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mi	alden Sumame)	
/lar	Vents	70	John Moser	Pearl		asper	
Maryland	2 sho and Is mu	1	(1)	ng Address (Street and Number or Rural i			Code)
2	and ealth m 27		1111	N. Second St., Oakl		21550 Dc. Location - City or To	wn Slate
Ore	ges 1 t of H If ite or ot		1 🗓 Burial 2 □ Cremation 3 □ Removal from State	matory or other place)		ŕ	
Ë	t. Partimentant:			ah Cemetery 6/12/		Valley Poin	
Baltimore,	Departing Important any ir		Katherine Sweiter	2. Name and Address of Facility Burd 21 N. Second	St., Oa	kland, MD 2	
			23a. Part I. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ve Heart Fa	91/010	2	I WK.
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1 1 11 4	Λ		-6
46	Examiner	_	Sequentially list conditions, b. Due to (or as a consequence of):	pulce Hear	Digeag	e	40902
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				/
_	xecut and II-trar	Examiner	that initiated events resulting in death) Last				
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit						
687	ficate p phys s the	edic	0.				
Box (eath certific attending p I for use as I	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Tetorio accompany		23d. Date of delive	*
B	death e atte d for	Physician/Medical	in the past 12 months? 4 Pregnant at time of death	□Ectopic pregnancy □ Other (specify)		Month	Day Year
0	that the de led by the a detached f	hys	9 Unknown				
S, P	es tha gned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the solution of the so	
ord	w requires to been signer should be	ted	Myocardal Interation		1 10:	4	
Vital Records,	S S S	ompleted			24a. Was an autopsy perform	prior to con	psy findings available inpletion of cause of
=		S			1 ☐ Yes 2	□ 1 □ Yes	2 □ No
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death Other: 4 Nursing Hom			
of	Phys this al dir	2	1 Yes 2 No 1 Sinpatient 2 EH/Outpatie	III 3 BOX 4 Indising Nom		nce 6 Other (Specified occurred)	v)
	ding h. After fune	tion	1/2Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No			
Division	i or Attending Pt after death, Director; After th in by the funeral	fica	2 Accident and Acc	reet, factory, office		eet and Number or Rura	i Route Number,
Ö	el or safter safter il Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical		th occurred at the time, date and place, are nvestigation, in my opinion, death occurred	nd due to the ca d at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	To th within To th comp	₹ S		29c. License number		d. Date signed (Month,	Day, Year)
			× (×//(D23979		68.6	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type			1	
_	12		Dr. Robert A. Goralski, 311 N. 4th S	treet, Oakland, MD	21550		
4	St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 1 2 2006 32. Registrar's Signature	backs			

DHMH 17 Rev 1/2001

ORIGINAL

		•	- State Amend Item	State of Mary 1 per Dr.,	dand / Dep G857,0//	artment of H 05 /06dhb rtificate of L	ealth and Me Death	ental Hygier Reg. r	ne2006	19261
4	Physicia		1. Decedent's Name (First, Middle, Last) Lillian Marie Ale	Lillian	Marie .	Alexandre		June 4,	^{Day} 2006 Year	3. Time of Death 10:23 PM
X	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	1
	Function		Kline Hospice Hous 5. Social Security Number 6. Sec		yrs. last birthday)	Mount Ai	If Under 24 Hrs. 8	3. Date of Birth	Frederick 9. Bint	place (State or Foreign
	Funeral Director		035-03-9737	M 2⊠F 92	Yrs.	Months Days	Hours Min.	Month, Day, Yea		le Island
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	he Mai	ector	Maryland Frederi	ck	Fred	erick		10-	0101	1XXYes 2 □ No
	3a or 3	i Dir	10e. Street and Number 200 East 16th Str	eet		10f. Zip Code 217	01		Citizen of What Cou United St	•
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If eath and Mental Hygiene. Item 27 Is marked other then "natural", or items 23s or 28s-f show other treumatic event, II a Medical Exams at must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XX Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2⊠ No	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	rfy Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: W.	
Maryland 21215-0036	within 72 horene. then "natural property of the property of th	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced (Give ///e.		ition uring most of working)		Kind of Business/l	
d 21	filed within Hygiene. other then	e Cor	17. Father's Name (First, Middle, Last)			Packer	18. Mother's Name (Drug Store
/lan	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, If a M	To B	Ovide Duhaime				Mary Fo	rcier		
Many	12 should h and Men 7 Is marke freumatic		19a. Informant's Name/Relationship (Ty			,	nd Number or Rural			ip Code)
	ges 1 and 2 t of Health if item 27 or other tr		Raymond Alexandre 20a. Method of Disposition	[2	260 Place of Dispo	WILCTLOWE: osition (Name of matory or other place	r Dr., Cra	te 20c.	$rac{1}{1} rac{02921}{000000000000000000000000000000000000$	Town, State
Baltimore,	Page ment o ant: If lury or		1 Burial 2 Cremation 3 XXP 4 Donation 5 Other (Specify)	emovar nom State	St. Ann C	Cemetery	2006	Cra	nston, R	node Island
Balt	permit. Pages. Department of the important: if ite eny injury or of once.		21. Signature of Future 13 styles Ucens	6	H 1	2. Name and Addres Oey-Arpin- 68 Academy	sof Facility -Williams- y Ave., Pr	King Funcovidence	eral Home , RI 0290	8
	· 漢 · · · · · · · · · · · · · · · · · ·	Ş.	23a. Parti. Enter the disease, or good shock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not ent	ter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co		FIBROS	15			years
ı	Examiner	_	Sequentially list conditions,). ————————————————————————————————————	anni anni att					
	uted d ansit	Examiner	Sequentially list conditions, if any, is a light cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	maequantija org					
,09289	eath certificate be executed ettending physicien and for use as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
Ψ	ertificat ling phy e as th		IF FEMALE:	10			***	- 55		
P.O. Box	iaw requires that the death certif as been signed by the ettending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of dela Month	very Day Year
	w requires that the de been signed by the e should be detached t	þ	Pan II. Other significant conditions con	mers Dis		inderlying cause give	on in Part I.			the cause of death?
Il Records,	The ate ha	Completed						24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of 2 No
of Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatier	nt 3□ DOA Othe	26. Place of Death (6 Koother (Spec	HOSTICE
ion of	fter fter iner	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		f 28c. Injury Work		d. Describe how in		11y) HOUSE
Division	st or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, sti Specify)	reet, factory, office	28	of Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of m ner: On the basis of ex- and mapper stated	amination and/or in	h occurred at the tim exestigation, in my op	e, date and place, an inion, death occurred	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier			29c. License		29d. [Date signed (Month	
	\		30. Name and address of person who or	ampleted cause of death	(Item 23a) /Tuca		2171		6/5/0	6
	V			DOGH POF	302 328	WALKERS	WILLE M	D 21753		
	Sta Regist		31. Date filed (Month, Pay, Year) 6 20	32. Figistrar's	Signature	book				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5

			For State Registrar		State of M	larylar	nd / Depa <i>Cei</i>	artment tificate	of Health an of Death	nd Mental Hy	/giene 2 (06	1926	2
			1. Decedent's Name	(First, Middle, Last)						2. Date of D		V	3. Time of Death	
	Physici /Medi		Joan		Ad	omine	S			June 3	Day 200	Year 6	0821 hrs₩	
	Examir		4a. Facility Name (If r	not institution, give s				4b. City, To	wn, or Location of [4c. County			
			4793 Ridg	ge Road				Mt. A	irv		Carro	11		
	Funeral Director		5. Social Security N <i>u</i> r 19 1– 24–899(nber 6. Sex	M 2∏F 7. A	ge (In yrs. 72	last birthday) Yrs.	If Under 1	fear If Under 24	Hrs. 8. Date of B Min. (Month, D June 21	ay, Year)	Cou	olace (State or Foreign ntry) Sylvania	
	pur A		Usual Residence of D 10a. State	ecedent 10b. County		10c. Ci	ty, Town or Lo	cation		<u> </u>			10d. Inside City Limits	_
	aho	5,						-					1 ☐ Yes 2 ☐ No	
	eiter death with the Marylan or itame 23a or 28e-f ahow indirer coast be notified at	Director	laryland	Carroll		Mt.	Airy	10f. Zip C	nde.		10g. Citizen of	What Cou	21	
	With and and and and and and and and and and	2											•	
	ne 23	Funerai	4793 Ridg		2. Was Deceden	t Ever in U	I.S. 13. \	217	4_1	n? (Specify Yes or N	United 2		es can Indian.	
	ter d	뒫	1 Never Married		Armed Forces 1 ☐ Yes 2√2	?	1	f Yes, specify	Cuban, Mexican, F	Puerto Rican, etc.)	Bla	ck, White,	etc.	
936	o Sin	ρ	3℃ Widowed 4		If Yes, Give Year or Dates			1□ Yes 2万	No Specify:		Specif	y: Whi	.te	
ŏ	a turi	ted		5. Decedent's Educ			16a. Deced	ient's Usual (occupation		16b. Kind of B	usiness/Ir	dustry	_
215	hin 7	pie	Elementary/Second	only highest grade	College (1-4or	5+)	life. i	DO NOT use	done during most or retired)	i working				
21215-0036	o filed within 72 hours effer death with the Maryland Hygiene. other then "natural", or Itame 23e or 28e-f ahow vent, the Myddical Examiner must be notified at	Completed			+4		Regi	stered	Nurse		Hospita	al		
		0	17. Father's Name (F	irst, Middle, Last)					18. Mother's	Name (First, Middl	, Maiden Surnar	ne)		
<u>Va</u>	should be nd Mental marked o	၉	James Mel	lvin O'Cor	nor				Floren	ce Reilly				
Maryland	and and is mu		19a. Informant's Nan		e, Print)			•		or Rurai Route Num			Code)	
≥.	and m 27 m 27		James Adon				4793 R	idge R	d.,Mt. Ai	ry, Maryl				
Baltimore,	permit. Pages 1 and 2 should be Depermit. Pages 1 and 2 should bental Important: If Itam 27 is marked any injury or other traumatic av gnce.			sition Cremation 3 □Re i □Other <i>(Specify)</i>	moval from State	,	Place of Dispo		· ·	Date	20c. Location		own, State Pennsylvar	. 1
喜	entine ortan		21. Signature of Fund		е	DL.	Peter			Stauffer F				11
ä	Den Person		Buc	10, 12	In at a O	•	8 F	ast Ri	doeville	Blvd., M	t Airv	Mri	21771	
1	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list conditions.	inal a.	Due to (or a	a consec	5 C quenca of):)	rdiac or respiratory	411 est,		Approximate Interval Between Onset and Death	
8760,	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	dical Examiner	Sequentially list conc cause. Enter Undert Cause (Disease or in that indiated events resulting in death) La	ijury c.	Due to (or a									
O. Box 6	nt the death certific by the attending p tached for use es	Physician/Me	fF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?	lc. If yes, outcom 1 □ Live birth 4 □ Pregnant : 9 □ Unknown	2 Feta	al death 3	Ectopic preg Other (spec	nancy fy)			ite of delivi	ery D ay Year	
rds, P.	quires that n signed b	þ	Part II. Other signific	ant conditions con	ributing to death	but not res	sulting in the u	nderlying cau	se given in Part I.		tobacco use cont Yes 2 □ No	tribute to t 3 ☐ Prot	he cause of death?	
of Vital Records,	The law requirete hes been page 2 should	Completed								24a. Waauto	psy ormed2	Were auto prior to co death? 1 \(\subseteq \text{Yes}	ppsy findings available mpletion of cause of	0
ta		0	25. Was case referre	d to medical					26. Place of	Death (Check only		103	20140	-
>	Physician: r this certific ral director,	0	examiner? 155⊈⊈es 2 ☐ N	lo He	ospital:	ient 2	ER/Outpatien	t 3 DOA	Other: 4 Nursi	\ /	idence 6 □Oth	ner (Specif	(v)	
	ing After	tion: T	27. Manner of Death Natural 2 Accident	5 Pending investigation	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	28c	Injury at Work?	28d. Describe	how injury occur			-
Division	P T T	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Ir building, e	njury - At h	ome, farm, str fy)	eet, factory, o	ffice		(Street and Numb wn, State)	oer or Run	l Route Number,	-
	Hospite 4 hours Funerei ely fille	Medicai C		Certifying Phys		of examina								-
	within 2 To tha complet	Me	29b. Signature and t	ne of certifier				29c. L	icense number		29d. Date signe	d (Month,	Day, Year)	\neg
			*ILIT	1: 10	~			DO	051924		June O	5,2	006	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Herbet P. Herberson Dr. Mn 3973 Manchester Rd Manchester MD 21102

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 13, 2006 **Physician** Buxenstein Elaine 7:15 pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 135 N. Mechanic Street Apt. 504 Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Bay, 1953 **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F VVV) 213-64-8556 52 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show eny injury or other treumatic event, it a Medical Examinar must be experient once. 10a State 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland MD Completed by Funeral Director 1 □X(es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. Mechanic Street Apt. 504 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home -17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmett Linville Macie (Slate) Boster P ^{19a.} Informant's Name/Relationship (Type, Print)
Valerie Stahlman
daughter 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State, Zip Code*) 11910 Iowa Drive Cumberland MD 21502 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 6/17/2006 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Scarbetts Furneral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infanction Presumed Physician /Medical Due to (or as a consequence of): Examiner THRIDM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed HTN Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, perchalesterolemia. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?, 3 Probably 2 🗆 No 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 HNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tust Magnons Mi D59407 15/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Anita Vagnoni, M.D. 621 Kelly Road Cumberland MD 21502 31. Date filed (Month, Day, Year) JUN 1 9 2006 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / I		nent of H cate of I		lental Hy	/giene	0000	19264
	Physic	ian	Decedent's Name (First, Middle, L Rachel		berta		Bohn		2. Date of D. Month	eath Da	y 7 Year	3. Time of Death 12 . 27 A.M.
	/Medi Exami		4a. Facility Name (If not institution, ga		33333	4b.	City, Town, or	Location of Death	Jai IC	40	. County of Deatl	
	Funeral Director	P	Lions Center for 5. Social Security Number 6. 219-14-5097	Rehab & Ex Sex 7. Ag 1□M 2∏F	t. Care e (In yrs. last bi	rthday) If	Cumbe Inder 1 Year on Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)		gany hplace (State or Foreign untry) vland
	<u> </u>		Usual Residence of Decedent		10c. City, Toy	m or Locatio			100/20/			10d. Inside City Limits
	/arylar	5		egany	Toc. City, Tov		' ımberl <i>a</i>	and				1 TYes 2 □ No
	r 28a-	Director	10e. Street and Number	-gany	1		of. Zip Code			10g. Ci	tizen of What Co	ountry?
	th with ust be	ai D	447 Baltimor	ce Avenue				21502			USA	
	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Medical Examinat must be a puffled at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Decedent of H , specify Cuba 'es 2 🙀 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
	2 hour	ted b	15. Decedent's	Education	168	. Decedent's	Usual Occup	ation during most of work	cina .	16b. K	(ind of Business/	
2	Maryland 21215-0036 of 2 should be filed within 72 hours aft the and Mental Hygiene. 27 Is marked other then "natural", or traumatic avent, the Medical Exemiterance.	Completed	(Specify only highest g	College (1-4or 5	5+)	life. DO N	OT use retired	during most or work	ung			
Q	nd 2121 e filed within al Hygiene. I other than '	S	12 17. Father's Name (First, Middle, Las	st)			Clerk	18. Mother's Nam	e (First, Middle	e, Maider	Retail	
5	Aarylanc 2 should be to and Menial H is marked of	To Be	Joseph	Peter	Ве	ecker		Rache	1	Can	rr	Hollenberge:
i	ary		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	dress (Street	and Number or Rui	ral Route Num	ber, City	or Town, State, 2	Zip Code)
	and 2 ealth am 27 i		Nancy L. Kegg /	daughter			-	e Avenue,	Cumbe:	7	d, MD 2	1502
(b)	Tore		20a. Method of Disposition 1 X Burial 2 Cremation 3		i		(Name of y or other place	ce)		ł		
Rachel	Baltimore, Mapermit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once.		' 4 □ Donation 5 □ Other (Specal Service Lice)	**.	MD Vet			cky Gap 0				Home, P.A.
2	Deg per S		Halut C	* Hel	and	404	Decati	ır Street	, Cumbe	erlan		21502
	Physician	ı	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each li				ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death Wally
	/Medical		resulting in death)	Due to (or as	a consequence							
	Lamine		Sequentially list conditions, if any, leading to immediate	b	a consequence	of):						
	8760, cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence	of):						
	ate ate	dicai		d					-			
	Box 6 ath certifi	Physician/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deal		opic pregnancy er (specify) _	1			23d. Date of del Month	livery Day Year
	p.O. I s that the de ned by the s	by Ph	Part ii. Other significant condition.	1 -	out not resulting	in the under	ying cause giv	en in Part I.	23e. Did	l tobacco	use contribute to	the cause of death?
	cords, wrequires been sign should be		Metaslatic	Lima	Care	(non	~e		1	Yes 2	No 3□Pr	robably 4 Unknown
	of Vital Records, Physician: The law requires t this certificate has been signe	Completed		<i>U</i>					24a. Wa aut per 1 ☐ Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
	Yital Reysician: The Is certificate had director, page	Be (25. Was case referred to medical examiner?	Hospital			0#	26. Place of Dea				
	□ gr eff eff	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	Hospital: 1 Inpati 28a. Date of Inju (Month, Date)	ury 28b	Time of Injury	28c. Inju	Nursing H	ome 5 Res		6 □Other (Spe ury occurred	cify)
	Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of In	ijury - At home, tc. (Specify)	farm, street,	factory, office			(Street a own, Stat		ural Route Number,
	na Hospita 24 hours na Funera	edical (Physician: To the best aminer: On the basis of and manner s	of examination a	ge, death oc und/or invest	gation, in my	me, date and place opinion, death occu	, and due to th	e, date ar	nd place, and due	e to the cause(s)
4	To ti with: To ti	Σ	29b. Signature and title of certifier	1			29c. Licens	se number		29d. D	ate signed (Mont	n, Day, Year)
	1			up tomo	doath (lto= 00-) (Tuna Dri-	103	2986)	J	ane 2,	2006
	nu		30. Name and address of person M	to: 625	Kent	AIR.		mberlo	and. N	DN	215	02
	Regis	tate	31. Date filed (Month, Day, Year)	2006 32. egist	trar's Signature	Soo	de .					

		1 - For Stete Registrar	State of Ma	ryland /	Departmer Certifica			nd Me	, ,	ene g. No./	006	1926
- ·		1. Decedent's Name (First, Middle, Last)					2	Date of Death	Day	Year	3. Time of Death
Physici /Medio		Emilie Elizabeth	Bradford						SUNE.	4	2006	1502
Examin		4a. Facility Name (If not institution, give				Town, or l	ocation of	Death		4c. C	ounty of Death	_
		TENINSULA REGION	7-7-12.		MA		5AL1-		4			nico
Funeral Director		5. Social Security Number . 6. Se 213-14-6138	ואר מעור	(In yrs. last b	Yrs. Months	Days	Hours	Min.	Date of Birth (Month, Day, 6/16/19	916	9. Birth	place (State or Foreig htry) MD
yland how		10a. State 10b. County		10c. City, Tox	vn or Location							Od. Inside City Limit
filed within 72 hours effer deeth with the Maryland Hygiene. ther then "naturel", or iteme 23a or 28a-f ehow ent, it a Medical Examination molified at	Director	MD Wicomi	со	Pitts	ville			<u> </u>		0		1 □ Yes 2√2 N
with t	ā	10e. Street and Number				Code			10	-	on of What Coul	ntry?
Ne 23	erai	7409 Gumboro Rd.	12. Was Decedent E	ver in IIS	13. Was Dece	.850	nanic Origin	n2 (Speci	fy Ves or No-		SA . Race - Americ	can Indian
I feath and Mental Hygiene. Heath and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, its Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:		If Yes, spe	cify Cuban	, Mexican, I Specify:	Puerto Ri	can, etc.)		Black, White,	
1 2		15. Decedent's Edu	cation	168	a. Decedent's Usu				1	6b. Kind	of Business/In	
en "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5-	+)	(Give kind of willife. DO NOT a	ork done du se retired)	ring most o	of working				,
ygien nt, me	Co	11			Seamstre						arment	
h and Mental Hygiene. 7 ie marked other then " traumatic event, <u>tra Me</u>	Be	17. Father's Name (First, Middle, Last) Alex Bradford						s Name (i le Bi	First, Middle, M	aiden S	umame)	
e mark	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)	19	b. Mailing Addres	(Street ar				City or	Town, State, Zip	Code)
m 27 i		Dr. David Lee Br	adford		544 Frie							
Department of Health a Importent: if Item 27 is any injury or other tra-		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F			of Disposition (Na ary, crematory or .ville Ce		1	Dat 5/7/0			tion - City or To	
ertme orteni injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Service Licens		rowell							ellvill uneral 1	
Depertr Importe any inju		1. Suc But	lasa						rlin, N			nome
hysician and popularity and the prize transit	dical Examiner	23a. Part1. Enter the disease, or compositions, or hear failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 13.7, 22d of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a complete to (or a) complete to (or a) c	consequence	of): PAILU ur):							Onset and Death
ate has been signed by the attending physically solution and page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 1 □ □ Unknown	Fetal deat	h 3⊡Ectopic p 5⊡ Other (s					23	d. Date of delive Month	ery Day Year
signed b	ρ	Part II. Other significant conditions co.	ntributing to death bu	t not resulting	in the underlying	ause giver	in Part I.			acco use	•	ne cause of death?
s certificete hes beer lirector, page 2 shou	Completed								24a. Was an autopsy perform 1 Yes 2		prior to co death?	psy findings available mpletion of cause of 2 \(\text{No} \)
within 24 hours after death. To the Funeral Directors After this certified completely filled in by the funeral director, to	Be	25. Was case referred to medical examiner?	Hospital:			Other			Check only one			
r this ral dir	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury			JA	4 🗆 14012		5 Resider		Other (Specification)	y)
ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M	28c. Injury a Work? 1 □ Ye	s 2 🗆 No			, ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
within 24 hours after death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, f . (Specify)	arm, street, factor	y, office		28	Location (Str. City or Town,	State)	Number or Rura	l Route Number,
n 24 hour ne Funera netely fills	edicai (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sicien: To the best o ner: On the basis of and manner stat	examination a	e, death occurred nd/or investigation	at the time , in my opin	, date and phion, death	place, and occurred	d due to the car at the time, da	use(s) ai te and p	nd manner as si lace, and due to	ated. the cause(s)
To the	Ň	29b. Signature and title of certifier	A . T			c. License					signed (Month,	
		Posta	ハ・ク			05	175	2	1 2180	0	4/20	206
2		30. Name and address of person who co		ath (Item 23a)	(Type, Print)	Palist	bules	m	1 .218	2/		
2	1	ו אווי שבווים				41112	4 20					

			1 - For State Registrar	State of M	larylar	-			lealth a Death	and M	R	eg. No.	006	19266
	Physici /Media		Decedent's Name (First, Middle, L.	William L		uskirk					2. Date of Deal Month	Day 3	Year 2006	3. Time of Death
\rangle	Examir	er	4a. Facility Name (If not institution, gi	ve street and number	7)		4b. City	Town, or	Location o	of Death	ио		LLEC	Mak
	Funeral		5. Social Security Number 6.	Sex 7. A	ige (In yrs.	last birthday)		Year	メヒド If Under:		8. Date of Birth (Month, Day,			
	Director		220-38-2474	1 Д M 2□F	65	Yrs.	Months	Days	Hours	Min.	November	<i>Year)</i> r 14, 194	0 Cour	place (Stale or Foreign ntry) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	10d. Inside City Limits
	Maryi I eho	ţo	Maryland A	llegany					Frostb	ourg				1 ☐ Yes 2 🗷 No
	or 28a	Director	10e. Street and Number				10f. Zij	Code			1	0g. Citizer	of What Cou	ntry?
	23a c	rai	19607 Bus	skirk Hollow F					2153				US	
36	nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland authent of Health and Mental Hyglene. Cortant: If item 27 ie marked other then "natural", or items 23e or 28e-f ehow injury or other traumalic event, the Madical Exertificat Iriual by Excilled at its 18.	Completed by Funeral	11. Marital Status 1 □ Never Married 2(X Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Tyes 2 5 If Yes, Give Year or Dates	i? €No	1	Was Dece f Yes, spe 1 ☐ Yes		ispanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:	
Š	2 hou	ted	15. Decedent's E (Specify only highest g			16a. Deced				t al warki	na	16b. Kind	of Business/In	
215	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT	ise retired			ng			. 0
7	Hygler Hygler Ither th	S	17. Father's Name (First, Middle, Las	0					Logger		(First, Middle, I			ment Operator
Maryland 21215-0036	should be find Mental History	To Be		Lloyd Van Bu	skirk						Ruth	Teresa	Snyder	
Mar	d 2 shoth and the and traum		19a. Informant's Name/Relationship Phyllis Busl			19b. Mailir					il Route Number, Road, Fros	-		
ē,	Health tem 27 other tr		20a. Method of Disposition	WIIIC WIIIC	20b. F	Place of Dispo	sition (Na.	me of	Ţ		ate		tion - City or To	
ē	Pages ient of int: If i		1 ☑ Burial 2 ☐ Cremation 3 i 4 ☐ Donation 5 ☐ Other (Spec		θ (cemetery, cren Mt.	View (June 06, 2006	Mo	scow Mil	ls, Maryland
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 2005		21. Signature of Funeral Service Lice			22	. Name a	nd Addres Ichhoi	s of Facility n-McK		Funeral Ho aconing,M			Main St.,
ı	Physician /Medical		23a. Panh. Enter the disease, or cor shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	CARR)IAL			g, such as			est,		Approximate Interval Between Onset and Death In CLIT
8760,	The law requires that the death certificate be executed to the speen signed by the ettending physicien and to age 2 should be detached for use as the burial-transit of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HXRER Due to (or a		juence of):	E CA	LDIV	JASC	-ULA	R 1015	EVS	ゼ	2 (0.) \$
P.O. Box 6	he death certific the ettending pl ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1⊟Live birth 4⊟Pregnant 9⊟ Unknown	2 Feta	ıl death 3 ☐	Ectopic p					23d	. Date of delive Month	ery Day Year
	res that the de signed by the e be detached f	by Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying (ause give	en in Part I,		23e. Did tob	acco use	contribute to the	ne cause of death?
rds	w requires been sign should be	ed b	Sculte multi	ple sole	rd51.	2					1 □ Ye	s 2 🗆 N	lo 3 ☐ Prob	pably 4 Tunknown
Division of Vital Records,	The law reste hes been	Completed									24a. Was an autops perform	y	prior to con death?	psy findings available mpletion of cause of
Vita	icien: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	Check only on	θ/		
on of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	tion: To	1 Yes 2	28a. Date of In (Month, D		28b. Time of Injury		28c. Injury Work	4 🗆 Nui	2	ne 5 Reside 28d. Describe ho			y)
Divisi	al or Attens after dea	Certification:	3 Suicide 6 Could not determine	be 28e. Place of li	njury - At h	ome, farm, str	eet, factor	y, office		- 1	28f. Location (St. City or Town	reet and N n, State)	um <i>ber</i> or Rura	il Route Number,
	he Hospit n 24 hours he Funere pietely fille	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the bes miner: On the basis and manners	of examina	owledge, death	occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to the ca	ause(s) and ate and pla	d manner as si	tated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier				29	c. License	number)	29	9d. Date s	igned (Month,	Day, Year)
			Mande Tin	reeng				000	185	1		lune	3 20	006
_	2		30. Name and address of person who Naval Manch	completed dause of	death (Item	1. 0	Print)	北屯	(u	MBt	BRLA IX	PA	1D. 2	1502
	Sta Registi		31. Date filed (Month, Day, Year) JUN - 6	2006 32. Regis	trar's Signa	ature	foots	2						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 11:35AM June 6, Neelima Bandopadhyaya /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Bethesda 8717 Burning Tree Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 T F June 9. 1929 India Director 76 none Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 mountains and Mental Hygiene.

I a marked other than "natural", or Itama 23a or 28a-f show the marked other than "natural", or Itama 23a or 28a-f show marke avant, the Medical Examinar must be notified at 1 X Yes 2 No Director unk unk New Delhi, India 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110029 India A-2/122 Safdarjang Enclave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Asian 1 Never Married 2 Married I □Yes 2 🛣No fYes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home es 1 and 2 should be filed voll Health and Mental Hygie of Health and Mental Hygie fitam 27 la marked other in other traumatic avant, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shibani Mukherjee Gouripada Chatterjee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amit Bandopadhyaya/son 8717 Burning Tree Rd. Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If its any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/07/06 Beltsville, Maryland Chesapeake Crematory Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** a Metastatic Pancreatic Cancer Months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the ettending physicien end the detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown The law requires thet 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2√2 No should 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s autopsy performed? 2□ No 1 Yes 2 🕅 No 1 ☐ Yes Division of Vital Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) None Hospital: 1 ☐ Inpatient ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Cartifying Physician: To the bast of my knowledge, death coursed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Carthar 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D42452 June 6, 2006 30. Name and address of person who and leted cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Pnilip Dr. #327 Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			, rot	Department of Health and M Certificate of Death	lental Hygie Reg.	ZUUb	19268
	Physici /Medio		Decedent's Name (First, Middle, Last) Constantine Balodimos		2. Date of Death Month 05	Day Year 19 06	3. Time of Death 16:25 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) NINSULA LIGIDIA MEDICAL S. Social Security Number 6. Sex 7. Age (In yrs. last birt	4b. City, Town, or Location of Death SAUGU thday) If Under 1 Year If Under A Hrs.	8. Date of Birth	4c. County of Death	Co place (State or Foreign
	Funeral Director		10XM 2015	Yrs. Months Days Hours Min.	Feb. 22,	1945 Wash	ington, D.(
	the Marylan 28a-f ehow rotting at	Director	10a. State 10b. County 10c. City, Town Maryland Worcester Ocea 10e. Street and Number	n or Location an City 10f. Zip Code	10g.	. Citizen of What Cour	1 M Yes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any Injury or other traumatic event, the Moulcal Examinar must be notified at once.	Funeral	13317 Atlantic Blvd. 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 13317 Atlantic Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21842 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Americ Black, White, Specify: White	etc.
Baltimore, Maryland 21215-0036	id within 72 hour giene. er then "natural	Completed by		Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Produce Manager	ing	b. Kind of Business/In	dustry
yland	nould be file I Mental Hy narked oth natic event	To Be (17. Father's Name (First, Middle, Last) William Balodimos	Angelik		dimos	
nore, Mai	ages 1 and 2 st nt of Health and t: If Item 27 fs n r or other traun		Peter Balodimos/Brother 133 20a. Method of Disposition 1	Mailing Address (Street and Number or Rura 317 Atlantic Blvd. October 1988) Disposition (Name of y, crematory or other place) acoln Cem. June Disposition (Name of y, crematory or other place)	cean City		own, State
Baltin	permit. P. Departme Important any Injury pnce.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility De V C 2222 Wisconsin Ave.	l Funeral	1 Home	
8760,	Physician and private be executed sittle physician and street transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentiarly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause). Due to (or as a consequence of the cause). Due to (or as a consequence of the cause). Due to (or as a consequence of the cause). Due to (or as a consequence of the cause).	Hypuapic K Heef 1	Jones	1 /1	Approximate interval Between Onset and Death
.O. Box 68	that the death certifics led by the attending ph detached for use as ti	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
Ω.	aw requires is been sign 2 should be	Completed by Ph	Part II. Other significant conditions contributing to seath but not resulting in	the underlying cause given in Part I.		co use contribute to the	**
Vital R	sician: The certificate h irector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 FR/Out	26. Place of Death	performed 1 ☐ Yes 2 🔀 a (Check only one)	d? death? No 1 ☐ Yes	2 □ No
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification; To	27. Manner of Death 28a. Date of Injury 28b. T	ime of North Month	28d. Describe how in 28d. Location (Street	t and Number or Rura	
ō	Hospital or 24 hours afte 7 Funeral Dir 8tely filled in 1	Medical Cert	29a. Certifier (Check only) Check only C	, death occurred at the time, date and place, a	and due to the caused at the time, date	e(s) and manner as st	ated. the cause(s)
	V To the within To the comple	Me	395 Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
				Salisbury, Maryland	21801		
	Sta Registr	- 1	31. Date filed (Month, Day, Year) JUN 2 2006 32. Registrar's Signature	Agerti			

Costantine Balodinos 900-24-3802

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 Gladys 27, Hardy Bonilla 8:10P May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5480 Wisconsin Ave. #911 Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F Director 579-40-9037 82 Sept. 22,1923 Honduras Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28e-1 show may injury or other traumatic event, the Madical Examination at once. 1⊠Yes 2 No Director Chevy Chase Md. Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5480 Wisconsin Ave. #911 20815 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Inter-American Elementary/Secondary (0-12) Coflege (1-4or 5+) Administrative Development Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Milton Hardy Margarita Taylor ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Parkson Road, Bethesda, Maryland 20816 Carlos Bonilla / Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 31,2006 Alex., Virginia 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 21. Signature of Fun raf Service Licer KURU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) ACUTE /Medical Due to (or as a consequence of) Examiner DIABETES 30 YEARS Sequentially list conditions, Examiner if any, leading to initiative cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signe 2 Should be c Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2X No 1 Yes After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Cther: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) မှ 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident within 24 hours after dea To the Funerel Director completely filled in by th 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23556 MAY 30, 2006 No 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Blee, M.D. 5530 Wisconsin AVe., #1400 Chevy Chase, Md. 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2006 Registrar

06-03297

Russell Dean Batson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Mussell Deall Dat		I- For State	tate of ivialyla		tificate of		ia ivicina		Reg No. 2 A	06 1927
Physicia	n/	Decedent's Name (First, Midd	dle,Last)					2. Date of De Month	Day Year	3 Time of Death
Medical Examin			sell	Dean		at son b. City, Town, o	r Location of	May 16,	2006 4c. County of D	1015 hrs
		4a. Facility Name (if not instituti 5976 Westchester Pa	_	mber)	ľ	College Pa		Death	Prince Geo	
Funeral	٩	5. Social Security Number		7. Age (In yrs. la	ist birthday)	If Under 1 Ye		24Hrs. 8. Date of E	Birth (MM/DD/YYYY) 9	. Birthplace (State or
Director		579-34-7232 Usual Residence of Decedent	1X M 2 F	77	Yrs	Months Da	ys Hours	Min. Aug	16, 1928 FG	Oreign Washington, Country) D.C.
w any	t	10a. State 10b. County	,	10c. City,	Town or Locati	on				10d. Inside City Limits
rland -f sho	ē	MD Prince	e Georges	Coll	lege Pa	r.k 10f. Zip Code			10g. Citizen of What	1 Yes 2 X No
vith the Maryland s 23a or 28a-f show a enotified at once.	Director	5976 Westchest	ter Park D	rive, #2	202		740		United S	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	Married Armed Fo					n? (Specify Yes or N Puerto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc.
fter de	引	3 Widowed 4 Di	1 Yes ivorced If Yes, Give Yea or Dates:	Korea	1	Yes 2X N	o specify:		Specify: W	hite
ours a latura xamit	od by	15. Decedent's Education (Sp.	ecify only highest grad	le completed)		t's Usual Occupa		nd of work done	16b. Kind of Busine	1
6 n 72 h an "n ical E	jet	Elementary/Secondary (0-12	College (1	-4 or 5+)		•				Aviation
003 withii grene.	ompleted	12 17. Father's Name (First, Middle	e Last)		Man	ager	18 Mother's	Name (First, Middle		istration
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Henry H.	Batson				Anna	•	Purdy	
212 ould bould bi I Ment is mark	일	19a. Informant's Name/Relation			19b. Mailing	Address (Stre			umber, City or Town, S	State, Zip Code)
MD d 2 sho lth and n 27 is		Susan McSween	y, niece						idge, VA	
ore, slan of Hea If iten		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 🛣 Removal fr	om State	rematory or otl			Date	20c. Location - Cit	·
Page ment or oth		4 Donation 5 Other		Fai		remator	′ I	6/2/2006	Fairfax,	
Baltimore, permit. Pages I at Department of He Important: If ite		21. Signature of Funeral Service	mits	zal'	10		n Stre	et, Fair	uneral Hom fax, VA 2	
Physician		23a. Part I. Enfor the disease, failure. List only one caus		aused the death.	Do not enter t	he mode of dying	g, such as ca	rdiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas				iovascular D	isease			Death
		or condition resulting in death)	Due to (or as a	consequence of	f):					
	je	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	f):					
	Examiner	(Disease or injury that initiated	D	consequence of	f):					
uted		events resulting in death) Last	d	,						
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED							
760 icate b physicate but the but		IF FEMALE: 23b. Was decedent pregnant in	the	outcome of pregi					23d. Date of de	· · · · · · · · · · · · · · · · · · ·
certific	Physician/	past 12 months?		oirth iant at time of de		etal death 3 ther (Specify)	Ectopic	pregnancy	Month	Day Year
Box e death c the atten	iysi	1 Yes 2 No 9 U	Inknown 9 Unkno	own	0 0	ner (opcony)				
O. lat the etache		Part II. Other significant cond	litions contributing to	death but not re	esulting in the I	underlying cause	given in Par			te to the cause of death?
rds, P.O. Box 687 requires that the death certifither been signed by the attending hould be detached for use as the state of the attending the detached for use as the state of the state o	ed by	Colon cancer					***	_		Probably 4 Unknown re autopsy findings available
of Vital Records, ng Physician: The law require when this certificate has been some and inector, page 2 should	Completed			··						r to completion of cause of
ital Recor ician: The law r s certificate has b	Som.							1 Yes		Yes 2 No
Vital I ysician: his certifi director,	Be (25. Was case referred to media examiner?	Il Inspitals				Othor	Check only one)		201
of Vining Physical After this	2	1 Yes 2 No		of Injury	ER/Outpatient		jury at Work?	Nursing Home 5 28d. Describ	Residence 6 🗸 (Other: Scene
n of National Physics of the Communication of the C	ion:	1 Mahural	28a. Date (Month	i, Day,Year)		· ·	Yes 2			
Division fal or Attendir rs after death al Director: A	To the proof of th								or Rural Route Number, City	
Division spiral or Attent hours after death nueral Director:	ertii	Julicide . L. 34	termined (Specify)					or Town	, State)	
F F		29a. Certifier 1 Certifying	Physician: To the best							
To the within To the comple	Medical	29b. Signature and title of certi	and manner s				nse number			(Month, Day, Year)
DI		70/011	RAK	1		0.0	C.M.E.		May 17, 2006	3
		30. Name and address of pers	on who completed cau	se of death (Item	1 23a)			<u> </u>		
-		Zabiullah Ali, M.D.	Assistant Medic			nn Street, Ba	ıltimore, M	1D 21201		
St Regis	ate trar	III N	2006 32.	egistrar's Signati	The Agent	weed?				

		1 - State Registrer	State o	f Mary			rtment <i>ificate</i>		ealth and Death	Men		iene g. No.	0	06	19271
Division		1. Decedent's Name (First, Middle, Las	st)								Date of Deat	h Day		Year	3. Time of Death
Physicia /Medic		Judith Bebar									une 3		06		4:57pm ^M
Examin		4a. Facility Name (If not institution, give	e street and nui	mber)		-	4b. City, T	own, or	Location of Deal	ıth		4c. C	ounty	of Death	
		Casey House					Rock					Mo	ont	gomer	
Funeral		5. Social Security Number 6. So	ex □M 2.2XTF		yrs. last birth	,	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min	s. 8. [Date of Birth Month, Day, r. 14,	Year)			ace (State or Foreign try)
Director		414-12-6906		8	36 Y	rs.				Ap	r. 14,	1920)	Tenn	essee
and *		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town	or Loca	ation							10	Od. Inside City Limits
Maryl f sho	ō	Maryland Montgome	1 T T T		Gaithe	rehi	11 1° C								1 ☐ Yes 2 🔀 No
28a	rec	10e. Street and Number	<u> J</u>		<u> </u>	1300	10f. Zip (Code			1	0g. Citize	n of W	/hat Coun	try?
3 a or	Funeral Directo	22201 Creekview D	rive				2	0882)		1	Inite	ad !	State	S
ms 2	era	11. Marital Status	12. Was Deci	edent Ever	in U.S.	13. Wa			panic Origin? (S , Mexican, Puer	Specify			. Race	- America	an Indian,
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Hedical Example or must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2 1 ₹] No ve			Yes, specif □Yes 2		Specify:	rto Rica	n, etc.)	s		k, White, 6 Whit	
2 hou		15. Decedent's Ed	ducation		16a. l	Decede	nt's Usual	Occupa	tion			16b. Kind	of Bu	siness/Ind	lustry
hin 7	Completed	(Specify only highest gra	College (1-4or 5+)		life. DC	na or work O NOT use	retired)	tion uring most of wo	orking					
gien et	МО	12			Le	ga1	Secr	etai	У			Law	Fi	rm	
a file	Be (17. Father's Name (First, Middle, Last)							18. Mother's Na	ame (Fir	rst, Middle, f	Maiden S	umam	в)	
Ment Ment arked	2	Burnett Sisk							Hazel C	Care	У				
and and is mu	1 5	19a. Informant's Name/Relationship (7	Туре, Print)		19b.	Mailing	Address (Street a	nd Number or R	Ru <i>ral R</i> o	ute Number	City or	Town,	State, Zip	Code)
and and m 27			ughter)		222	201	Creel	kvie	w Drive						
2 = = = = = = = = = = = = = = = = = = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	State 2	0b. Place of l cemetery	Disposit , crema	tion (Name atory or oth	e of ner place)	Date		20c. Loca	ition -	City or To	wn, State
mit. Pages partment of portant: If I y injury or		4 □ Donation 5 □ Other (Specify			Metrop					5/4/					Virginia
Departition on in one i		21. Signature of Funeral Service Licen	Ley_			10	East	Dee	of Facility Der Park g, MD 2	Dri	ve	eral	Hon	ne	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that o	aused the	death. Do no							est,			Approximate Interval Between
Physician	0. 1	Immediate Cause (Final			irato	ev E	Foflu	*0							Onset and Death
/Medical		disease or condition resulting in death)			irato:		rallu	re					_	_	
Examiner			Coror	ary A	Artery	Dis	sease								
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tth ce ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗌	Fetal death	3 □E	Ectopic pre	gnancy				23	d. Date Mon	of deliver	ry Dav Year
the all	SICI	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4∏Pregr 9⊟ Unkn	nant at time own	of death	5 🗆 C	Other (spe	cify)					WIOI		Day
d by letach	F.	Part II. Other significant conditions c				41			1- B - 1	T	07- Dida-				
Physicien: The law requires that the death certificate this certificate has been signed by the attending ral director, pege 2 should be detached for use as	δ	Part II. Other significant conditions of	ontributing to a	eath but no	or resulting in	tne una	enying car	use give							e cause of death? ably 4XUnknown
aw requas been 2 should	Completed										24a. Was a		24b. V	Vere autop	osy findings available appletion of cause of
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clen: cartifice ector, p	Bec	25. Was case referred to medical							26. Place of De						
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oding Phy ith.: After this funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date (Mon	of Injury th, Day Ye	28b. Ti	me of jury	M 28	c. Injury Work	at ? es 2 □No	28d.	Describe ho	w injury	occurre	ed	-
or Attending after death. Director: Attellin by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	of Injury - ing, etc. (S	At home, fari pecify)	m, stree	et, factory,	office		28f. I	Location (St. City or Town	reet and . , State)	Numbe	er or Rural	Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 🔀 Certifying Ph (Check only 2 🗌 Medical Exam	niner: On the b	asis of exa											
o the ithin 2 o the	Med	one) 29b. Signature and title of certifier	and man	ner stated.			29c.	License	number		2	9d. Date	signed	(Month, E	Day, Year)
F 3 F 8		Cynthia M	Dull	10	7	00				,					
S		30. Name in address of person who			(ltem 22a) 7	Type D-	rint)	UU.	10002	-		June	4,	2006	0
		The state of the s	11.114	ms	DO	600	31 1	Nus	caster	r 1.	nill	Roci	Kvij	1/e, M	10 20851
Sta Registi		JIIN 5 200	36	agistrat s	Signature	and	20								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 05, 2006 **Physician** Alma Margaret Cunningham 03:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 9 Centennial Street Allegany Frostburg 5. Social Security Number 213-72-4934 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year 08-Oct-1907 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 😿 F 98 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23e or 28e-f show dical Examiner", ust be notified at Maryland 1 Yes 2 □ No Frostburg Allegany Director 10e. Street and Number 9 Centennial Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grant Deibler Rachael McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Diamond 79 W. Main Street daughter Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Saint Michael's Cemetery 08-Jun-2006 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn Approximate Interval Between Onset and Death sa. In 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CURUN ATRY **Physician** 1) 1S12/75/2 15-years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 2 No Day Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 Malpon walsh Road, Cumberland, Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop M.D. Sidhu 31. Date filed (Month, Day, Year) State 2006 Registrar

DHMH 17 Rev 1/2001

		٠,	State of Maryland / Department of Heal State of Maryland / Department of Heal Certificate of De			giene 20	06	19273
			Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		Ruth Catherine Carmody		May 28	, 2006	1001	4:35 A ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County		
			Suburban Hospital Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year III	Under 24 Hrs.		Montg		
	Funeral Director		130-22-3685 1□ M 2⊠F 78 Yrs. Months Days H	Hours Min.	8. Date of Birtl (Month, Day Aug. 12	1927 1927	Cour	place (State or Foreign ntry) York
	pur *		Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Aarylä Poho	ō	Maryland Montgomery Wontgomery Village					1⊠Yes 2 No
	the t	ect	10e. Street and Number 10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a or	٥	9313 Vineyard Haven Drive 20886			United	Stat	tes
	ms 2	nera	11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa tr Yes, specify Cuban, M	anic Origin? (Spec	cify Yes or No-	14. Rac	ce - Americ	can Indian,
36	72 hours after deeth with the Maryland natural, or items 23e or 28e-f ehow disal Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Specify:	noan, etc./	Specif		
Ş	2 hou	ed	15 Decedent's Education 16a, Decedent's Usual Occupation	n		16b. Kind of B		
215	hin 72 n "na Medi	ple	(Specify only highest grade completed) (Give kind of work done durin life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ng most of workin	ng			
217	filed within Hygiene. Ither then "	E O	12 - Homemaker			Own	Home	
Maryland 21215-0036	9 0 0 0	To Be (Control of the contro	3. Mother's Name Elsie Tr			ne)	
2	shour ind M mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Number or Rural	i Route Numbe	r, City or Town	, State, Zip	Code) 20886
	alth a		Dennis F. Carmody/ Son 9313 Vineyard H	laven Dri				
Baltimore,	ages 1 and of He It if item / or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Charles Cemetery	June		Farmi		own, State Le,
盲	ertme ortani injun		4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of	2006 of Facility De		New neral H		
Ba	Depermine Depermine Important in police.		Curtis E. Way 10 East Deer					, MD 20877
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line.	such as cardiac or	r respiratory ar	rest,		Approximate Interval Between
	Physician		timmediate Cause (Final disease or condition a LUNG CAUCE R	7.				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):					5/22/5
	Examiner		Sequentially list conditions.					
-	pg tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
_	and and Il-tran	хап	resulting in death) Last Due to (or as a consequence of):				-	
68760,	icate be executed physicien and s the burial-transit	al E					ì	
687	ficate physics the	edicat	d,					
35°	leath certific attending p I for use as t	M/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Da	ite of delive	ery
943.	The law requires that the death certif Ne hes been signed by the attending bage 2 should be detached for use as	Physician/M	n the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Yes 2 □ No 9 □ Unknown			Mo	onth	Day Year
. q.	 requires that the deben signed by the should be detached 	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
at at	signe d be	d by			1 20 Y			pably 4 Unknown
Suth ob a ecord	w requ	ete			24a. Was	an 24h	Were autr	onsy findings available
Re Be	The lav	Completed			autop	med?	death?	opsy findings available impletion of cause of
- 22 E		Be C	25. Was case referred to medical 26	6. Place of Death	717 177		1 🗆 Yes	2D No
201	ysicius cer direct	To B	examiner?	4 ☐ Nursing Hom			ner (Specif	(v)
Mary XP;	ding Physician: h. After this certific funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ow injury occur		
R C Ex Sion	ttendir death. ctor: Af y the fu	atlo	2 Accident investigation M 1 Yes	2 🗆 No				
CAR M Exp Division	of or Attender after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2.	8f. Location (S City or Tow	Street and Numb n, State)	oer or Rura	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion					
	the thin 2. the fundamental th	Medical	and manner stated. 29b. Signature and title of certifier 29c. License nu			29d. Date signe		· · ·
	_		29C. License nu	1///		LAN I	\ \(\omega\)	1 (
	10		Miller M. J. J. S	10/6		mate	1010	1006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUSDN Kalil, MD 5454 WIJGNJIN AKI	PHILL 12,	22 (HE	RICI CHA	15	MD JORIS
	Sta	te	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	1000	- 0111	29 CIN	-0 1/	VID ON (1)
	Registr		JUN 2 2006 Brown & March					

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 27, 2006 Year 12:24 PM Suzanne Cardillo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 11 Walker Avenue Gaithersburg H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Day, Year Dec. 16, 1947 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2점F 214-48-9016 58 Vrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Insportant: if item 27 is marked other than "natural", or items 23a or 28a-f show my jury or other treumatic event, in a Medical Examination incitied at once. Maryland Gaithersburg Montgomery 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20877 11 Walker Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Home Improvement Elementary/Secondary (0-12) College (1-4or 5+) 12 Head Cashier Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Jane Sudduth John Robert Eisel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Walker Avenue, Gaithersburg, MD 20877 Kenneth P. Cardillo/ Husband 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 1. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Memorial Park 2006 22. Name and Address of Facility DeVol Funera
Park Drive, Gaithersburg, Ma

23a. Part Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the part failure. List only one cause on each line.

Metastatic Lung Cancer

a. Metastatic Lung Cancer 22. Name and Address of Facility DeVol Funeral Home, 10 East Park Drive, Gaithersburg, Maryland 20877 Approximate Interval Between Onset and Death **Physician** one year /Medical Due to (or as a consequence of): Examiner Unknown Small Cell Cancer of the Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 🛂 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cete has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D21531 May 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN

2006

G. Peter Pushkas, M.D., 11510 Old Georgetown Road, Rockville, MD 20852

32 Registrar's Signature

		1	For State Registrar	State of M	arylan		artment of tificate of			F	leg. No.	006	19275
	Physicia		Decedent's Name (First, Middle,			-				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al .	JOHN	В.		CRUPI	45 City Town		4 Doodh	June	01_	2006 nty of Death	
	Examin	er	4a. Facility Name (If not institution,		44.2	an/m	4b. City, Town	n, or Locatio	on of Death	,	46. Cou	_	mico
			5. Social Security Number	6. Sex 7. Ac		last birthday)	If Under 1 Ye	ar If Und	ler 24 Julis.	8. Date of Birt	h		place (State or Foreign
	Funeral Director		184-22-9178	1 ⊠ M 2□F	76	Yrs.	Months Da	ys Hour	s Min.	(Month, Day 2-3-1	930°	Cou	NNSYLVANIA
			Usual Residence of Decedent		T								
	aryien show	_	10a. State 10b. County	CEV	10c. Cit	ry, Town or Lo	VILLE						10d. Inside City Limits 1 ☐ Yes 2 No
	Be-f	Director		SEX	1	LITTI	10f. Zip Cod				10g. Citizen	of What Cou	
	72 hours after death with the Marylend natural; or iteme 23e or 28e-f ehow deat Examinat must be notified at		10e. Street and Number RD #2 BOX	105				19967				D STAT	-
	ne 23	Funeral	11. Marital Status	12. Was Decedent		.S. 13.	Was Decedent of f Yes, specify C		Origin? (Spe	cify Yes or No	14. F	Race - Ameri	
(0	r iter	Fun	1 ☐ Never Married 2 X Marn	Armed Forces	No		f Yes, specify 0 1 ☐ Yes 2 1221			Hican, etc.)		Black, White,	
93	rai'. o	J p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	52-	54	10 105 2001	NO Speci	ny.		Spe	cify:	WHITE
5-0	72 hours "natural", dical Ex	etec	15. Decedent (Specify only highes	's Education it grade completed)		(Give	dent's Usual Oc kind of work do	ne during m	ost of worki	ng	16b. Kind o	f Business/Ir	ndustry
21215-0036	I within 72 ho iane. r then "natur the Mcdical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use re LEF CUS'		ī		EI	UCATI	ON
5 D	be filed v tel Hygia d other l	ပိ	17. Father's Name (First, Middle, I	Last)						(First, Middle,		nam <i>e)</i>	
Maryland	7 2 5 9	To B	JOHN CRUPI					1	MARIA I	MESSINA			
ary			19a. Informant's Name/Relationsh	hip (Type, Print)			ng Address (Str						
	1 and 2 Health a em 27 is		EMMA A. CRUPI/	WIFE			#2 BOX						
Baltimore,	Pages nent of nt: If it iry or o		20a. Method of Disposition 1 Definition 2 Donation 5 Other (S)		206.	Place of Disponder Company of Taware Mortal	sition (Name of matery or other CEMETE	(135°) RY		2006		on - City or T	own, State DELAWARE
Balti	permit. Pag Department Importent: any injury once.		1. Signature of Figural Sorvice	Man (M W	Name and Ac ELSON F EST AVE	UNERAL OC	L'SERV EAN VI	ICES, I	TB970		
			23a. Part1. Enter the disease, or shock, or heart allure. List	complications that cause only one cause on each	d the deat	th. Do not ent	er the mode of	dying, such	as cardiac o	or respiratory ar	rest,		Approximate Interval Between
J.	Physician		Immediate Cause Final disease or condition	Anax	_	Brain	Thi	144					Onset and Death
7	/Medical		resulting in death)	Due to (or as	a consec	quence of):	-		^				
Ц	Examiner		Sequentially list conditions,	b. Vent	ricu	lar	achyc	ard	ia Hr	rrest		- 1	Days
	pe isi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consec	tuence or):	رير ماير	D:	000	o			Herrs
	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consec	quence of):	7 70 9	<u> </u>	seas				9000
760,	sician buria	calE											
687	ficate g phys	-		0.									
Box	that the daath certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			DEctopic pregna	ancv			23d.	Date of deliv	•
	daatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specif)					Month	Day Year
P.0.	at the by th	hys	9 ☐ Unknown							nna Dida	ab	ant-but- to	the enuse of death?
	requires that the daath certifica wen signed by the attending ph hould be detached for use as th	<u>م</u>	Part II. Other significant condition	Continuo	but not res	suiting in the u	inderlying cause	given in Pa	art I.				the cause of death?
ő		etec	12916	2 (0.1110.)						24a. Was	an 2	th Were aut	onsy findings available
Division of Vital Records,	sicien: The law certificate has b irector, page 2 st	Completed								autop	rmed?	death?	opsy findings available ompletion of cause of
a	n: Th flicate or, pa	e Co	25. Was case referred to medical	1			-	26 PI	lace of Death	1 ☐ Yes		1 🗆 Yes	2 No
₹	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minpat	ient 2] ER/Outpatie	nt 3□ DOA	Other		me 5 Resi		Other (Spec	ify)
10	g Phy er this neral c	ı.	27. Manner of Death	28a. Date of Inj		28b. Time o		Injury at Work?		28d. Describe			
<u>ö</u>	ath. r: After	atio	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	-, , ,	,,		1 ☐ Yes 2	!□No				
ΝİS	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of In building, 6	njury - At h	nome, farm, st	reet, factory, off	fice		28f. Location (. City or To		umber or Rui	ral Route Number,
	ital o ris aft rei Di								CARL DE				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 1 Certifyir (Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner s	of examin	owledge, deal ation and/or in	vestigation, in r	ny opinion,	death occurr	and due to the red at the time,	date and pla	ce, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifie	or			1	cense numb			29d. Date si	•	, Day, Year)
			1								C12	201	
	V 11		30. Name and address of person	who completed cause of	death (Ite	m 23a) (Туре	Print) UST.	6	1.1	na.n	2,1	121	
	1071		STEVEN E. HEAL	NE VILD /C	trar's Sign	ature	4 31.	2/1/	15001	y ma	010	01	A ACCOUNT OF THE PARTY OF THE P
	St Regist	ate rar	JUN 0	6 2006	O an a	nature	had.						
		-				J. J.				10			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State
Registrar/MEND#27, per/MD6/5/06, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 28, 2006 4:55pm Marilyn L. Crockett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery 18616 Chickadee Lane If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** 1 ☐ M 2 🖾 F Director 217-42-2964 60 July 4, 1945 Washington, DC Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. tnside City Limits 10b. County 10a. State or Items 23a or 28a-f ehow the Medical Examiner rount be notified at 1 Yes 2 No Directo Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20879 United States 18616 Chickadee Lane 2 should be filed within 72 hours after death is and Mental Hygiene.

Is marked other then "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Accounting Department of Heelitt and Mental Hyginportant: If Item 27 is marked other eny injury of other treumatic event, and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy L. Herr Howard Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 s nent of Heelth an ant: If Item 27 le 18616 Chickadee Lane, Gaithersburg, MD 20879 Randy Crockett (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/2/06 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licequee 10 East Deer Park Drive Gaithersburg, MD 20877 List N. 4 Approximate tnterval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** a <u>Probable</u> Heart Attack /Medical Due to (or as a consequence of): Examiner b Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day ō 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 XNo P.O. 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 305 page 2 autopsy performed? 1 Yes 2 X No Division of Vital 25. Was case referred to medicat examiner? director Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) ۵ 1 XYes 2 □ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No efter death. Director: Af investigation 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 🗌 Homicide within 24 hours e To the Funeral E 29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number 2005768 5 06 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 501 N. Frederick Ave., Gaithersburg, MD 20877 Meaza Gebreselassie, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 5 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2006 June 2. 2:25 A M Dixon Stephen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, May 10, 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2□ F 1958 Washington, D.C. Yrs. 48 Director 217 72 3573 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Annapolis Anne Arundel Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? USA 21409 1189 Highview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Surveying Company Surveyor . Pages 1 and 2 should be filed w timent of Heelth and Mental Hygie tant: If Item 27 Is marked other ti jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Murphy Unknown Jes 1 and Jes 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Amanda Cunningham / Personal Rep. 1189 Highview Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lkemont Mem. Gardens 6/5/2006 Davidsonville, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enjer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cancer OMa **Physician** o mos. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immuscrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or se si consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 □Ectopic pregnancy Month Dav Year 4□Pregnant at time of death signed by the at id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 □ Yes 2 □ No 3 Probably 4 □Unknown been 24b. Were autopsy findings avaitable prior to completion of cause of death? 24a Was an s certificate has t 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral. 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospitel 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) 5 JUN

2006

29b. Signature and title of certifier



Bestgate Rd. Annapolis, Md. 21401

29d. Date signed (Month, Day, Year)

Delauter, Glenn B DOB 11/20/25 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene DOD 6/2/06 @ 820/6 Reg. No. 4 UU 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 5 , **Physician** Glenn Blickenstaff DeLauter June /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Julia Manor Nursing Center Hagerstown If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1☐xM 2☐ F Months Hours 220-26-0516 80 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural" ~- the any injury or other traumatic event 10a, Stete 10b. County 10c. City, Town or Location Funeral Directo Maryland Frederick Sabillasville 10e. Street end Number 10f. Zip Code 15316 Quirauk School Road 21780 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer/School Bus Driver 17. Fether's Neme (First, Middle, Last) Glenn Leon DeLauter 19a. Informant's Name/Relationship (Type, Print)

4c. County of Death Washington 8. Date of Birth (Month, Day, Year) Nov. 20, 1 Birthplace (State or Foreign Country) 1925 Maryland 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Farming/Education 18. Mother's Name (First, Middle, Maiden Sumame) Daisy Blickenstaff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. DeLauter / Grandson 6124 Samuel Road, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem UMC Cemetery 6/10/06 Wolfsville, Maryland 22. Name and Address of Fecility KOBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 Part1. Enter the disease, or complication shock, or heart failure. List only one cau Do not enter the mode of dying, such as cardiac or respiratory arrest, that caused the death. Immediate Cause (Final disease or condition resulting in death) Due to (or es a conseduence of): Examiner Cell Carcinoma 2quamus Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Hypertension Physician/Medical Due to (or es a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Typs 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury et Work? 27. Megrer of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 12060396 06 06 06

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or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After compliataly filled in by the fun

Physician /Medical

Examiner

attending physician and for use as the burial-transit

State Registrar 1126

30. Name end eddress of person who completed cause of death_(Item 23e) (Type, Print)

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To B	0	EDWIN BAKER	ł						NETT]	E RE	VEL			
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			For State Registrar	State of Ma	arylan				ealth a Death	and M	ental H	ygiene Reg. No.	2006	19281
	Disconini		1. Decedent's Name (First, Middle, Last)				·				2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic			William Frai	ncis Fi	tzpatrick					00	Ole	000	1351 "
	Examin		4a. Facility Name (If not institution, give s		0.15		4b. City	Town, or	Location o	f Death	_	4c. (County of Deat	0
			5. Social Security Number 6. Sex			ast birthday)	If Unde	2 Year	If Under 2	24 Hrs.	B Date of B	idh F		holace (State or Foreign
	Funeral Director			M 2□F	73	Yrs.	Months		Hours	Min.	8. Date of B (Month, L Novem	ber 15, 19	932	hplace (State or Foreign buntry) Maryland
			Usual Residence of Decedent											
	nylan show	h	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	Ba-f o	Director		gany			104 7	o Code	Bart	on		10a Citia	zen of What Co	
	with ti	吉	10e. Street and Number	ow Street, S.	W/		101. 21	Code	2152	1		Tog. Citiz		ISA
	eath	era		12. Was Decedent		S. 13. 1	Was Dece	dent of Hi			cify Yes or N Rican, etc.)	10- 1	14. Race - Ame	erican Indian,
36	rs after d	by Funeral	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:			lf Yes, spe 1 □ Yes	./	n, Mexican Specify:	, Puerto F	Rican, etc.)		Black, Whit Specify:	e, etc.
8	thour sture	edit	15. Decedent's Edu	cation		16a. Dece						16b. Kir	nd of Business	Industry
75	in 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give life.	kind of wi DO NOT i	se retired			ng		-	
2	d with giene	E O	12	2	,				Railroa					rain
and	ld be file ental Hy ked oth c event	To Be Completed	17. Father's Name <i>(First, Middle, Last)</i>	Illiam Fitzpa	trick				18. Mothe	r's Name	(First, Midd	e, <i>Maid</i> en . Beatrice	_	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: If them 27 is marked other then "naturel", or Items 23a or 28a-f show eny Injury or other treumatic event, I'm Medical Examinar must be nutited at once.		19a. Informant's Name/Relationship (Ty. Joan Fitzpatri			19b. Mailir	•					-	Town, State, a Maryland	
ē,	f Hee f Hee othe		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Na	me of other plac	e)	D	ate June 10,	20c. Lo	cation - City or	Town, State
Ë	Page nent o int: If	li	1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		int Gabr				ry	2006		Barton,	Maryland
Balti	permit. Depertrimports eny Inju		21. Signature of Funeral Service License	99		22	2. Name a	Eichho	is of Facility		Funeral		P.A. East 539	Main St.,
			23a. Part1. Enter the disease, or complishock or heart failure. List only or	ications that caused ne cause on each li	the death									Approximate Interval Between Onset and Death
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	/Medical Examiner		1 douting in douting	Due to (or as	a consequ	uence of):								
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8760,	cate b physic the b	dica		d										
9 x	leath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome								2	23d. Date of de	livery
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P.0	res that the signed by th be detache		Part II. Other significant conditions con	ntnbuting to death b	out not res	ulting in the u	inderlying	cause givi	en in Part I.		23e. Dic	tobacco u	se contribute to	the cause of death?
of Vital Records,	law requires as been sign 2 should be	Completed by	Hypertension	Hyperl	ipid	emio	2				10	Yes 2	□No 3□Pi	robably 4 Monknown
Ö	w requires been si	siete	11	1 "	1						24a. Wt		24b. Were at	utopsy findings available
Be	he hege	E									per 1 Yes	opsy formed? 2 No	death?	completion of cause of
ita	certifice rector, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			
>	Physician: this certific ral director,	70	1 ☐ Yes 2 🗷 No	lospital: 1 🗌 Inpati		ER/Outpatier	_		4 110				3 □Other (Spe	ocify)
	De fe	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time o Injury		28c. Injun Worl	k?		8d. Describ	e how injury	y occurred	
Sio	Attending in death.	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	iury - At ho	ome farm st	M reet facto		Yes 2 🗌		8f. Location	(Street and	d Number or R	ural Route Number,
Division	at or A after I Direct d in by	Certification:	4 Homicide determined	building, e	tc. (Specif	y)	reor, racto	y, onlos			City or T	own, State))	oral riodio realipor,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier 1 Certifying Phy (Check only one)		of examina									
	To the vithin 2 To the comple	Med	29b. Signature and title of certifier		17.		29		e number				e signed (Mont	
	- s - ō	1 8	1 cm	2/1				0	056	100	4	6	17/0	6
			30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type,	Print)		Λ				1110	
		4	Dr. Shiv Khann	2 62	5 Ke		1enu	e	Cu	mbe	rland	MD	17/0	07
	St. Regist	ate	31. Date filed (Month, Day Year)	32. Regist	rar's Signa	iture	Ann.	S				*		

		1	For State Registrar	tate of Man		artment of rtificate of		ind Mental		ne 006	19282
			Decedent's Name (First, Middle, Last)					2. Date Mont	of Death	Day Year	3. Time of Death
	Physicia /Medic		Earlie M. Foun	taine		,		May		2006	6:40A M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, Town,		f Death		4c. County of Dea	
			Sligo Creek Nursing H		for all hilleds afour	Takom If Under 1 Yea	a Park	24 Hrs To Date	of Righ	Montgan	
	Funeral		5. Social Security Number 6. Sex 1 □ M	o February	n yrs. last birthday) 32yrs Yrs.	Months Days		Min. (Mon.	of Birth th, Day, Y		rthplace (State or Foreign ountry) rginia
	Director		Usual Residence of Decedent					indy	102	- V-	<u> </u>
	yland	. [10a. State 10b. County	10	Dc. City, Town or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
	B Maria	ctor	MD Montgamer	¥	Takom	a Park					
	or 28	Dire	10e. Street and Number			10f. Zip Code 20912			10g	Citizen of What C United S	
	s 23e	ral	7525 Carroll Avenue	Was Decedent Eve	rin II C 12			gin? (Specify Yes	or No-	14. Race - Am	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or Items 23e or 28e-f show importent: in item 27 is marked other than "natural", or Item 27 is marked other than "natural". Once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cu	iban, Mexican	, Puerto Rican, et	c.)	Black, Wh	ite, etc.
Š	2 hou	Completed	15. Decedent's Educa' (Specify only highest grade of	ion ompleted)	16a. Dece	dent's Usual Occ	upation e during most	of working	16	b. Kind of Busines	s/Industry
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Maryland	ntal H ed ott	Be	17. Father's Name (First, Middle, Last) Chetister Anderso	n				Carah Nel		addir damamay	
Ž	should nd Me mark matic	٦	19a. Informant's Name/Relationship (Type	Print)						City or Town, State,	Zip Code)
Z	alth ar 27 is r treu		Ina R. Mendoza (d	aughter)	3540	Crain Hig	ghway Ap	t.#270, B	owie,	MD 20716	
altimore,	itam itam othe		20a. Method of Disposition	State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other p	lace)	Date	20	c. Location - City o	r Town, State
E	Page 1 2 2		1 ☑ Burial 2 ☐ Cremation 3 ☑ Aer 1 ☑ Donation 5 ☐ Other (Specify)	noval from State	Crest F	ill Cemete	ery J	une 2, 200	0	rest Hill,	
alti	rrmit. spartn sporte iy inju		21. Signature of Fundial Service Licensee	/						I Service,	
<u>—</u>	20.5 2 2		23a, Part1. Enter the disease, or complica	wysou						on DC 2001:	Approximate
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O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	i. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	⊒Ectopic pregnar ⊒ Other (specify)				23d. Date of d Month	elivery Day Year
ds, P.	uires that signed b	by	Part II. Other significant conditions control Hypertension, Atr			underlying cause	given in Part I	. 23e			to the cause of death? Probably 425Unknown
Vital Records,	The law requirate has been page 2 should	Completed	Congestive Heart	Failure					. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of
<u>ta</u>	-	BeC	25. Was case referred to medical examiner?					of Death (Check	only one)		
of V	Physician: this certificated ral director.	To	1 ☐ Yes 2 🔀 No		2 ER/Outpatie	HIL JUDON				ce 6 □Other (Sp	pecify)
n c		lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time (V	ijury at Vork? □Yes 2□		scribe now	injury occurred	
Sic	Attanding r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	/ - At home, farm, s				ation (Stre	et and Number or	Rural Route Number,
Division	E Die	Certification;	4 Homicide determined	building, etc.	(Specify)			City	or Town.	State)	
_	To the Hospital or Attanowithin 24 hours after deatl To the Funarel Director: completely filled in by the	Medical C	29a. Certifier 1% Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of r: On the basis of e and manner state	xamination and/or i	th occurred at the nvestigation, in m	time, date ar y opinion, dea	nd place, and due at the	to the cau time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1	2 ~		ense number	777	290	d. Date signed (Mo	nth, Day, Year)
)	. w 1		Maris 1 7	ral &	m	2	00 58	116	J	une 1, 2006	
	X.		30. Name and address of person who com				#212 -	To object	DC 20	01.7	
		oto	Doris V. Pablo-Bustos, 31. Date filed (Month, Day, Year)		O Varnum S		π Δ 13, V	vasi migton	LL 20	017	
	St Regist	ate trar	JUN 2 20	06 Strew	s Signature	parti					

		1 - State Registrar	State of Mary	77,6776 Ce	706th of H	ealth an D <i>eath</i>	d Mental Hyg	giene Reg. No.	06	192	283
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of 0	Death
Phys	ician dical	Doreth	a L. Fonta	ny			June			6:05	A^{M}
Exam		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of D	eath	4c. County of	of Death		
		Montgomery Village			Gaith	ersburg			gomer		
Funer	_	5. Social Security Number 6. Sex 1□	M 21XF 7. Age (In yi	s. last birthday) Yrs.	Months Days		Hrs. 8. Date of Birt Min. (Month, Date Jan. 22	h v. Year) 1017	9. Birthplac Country, PA	e (State or)	Foreign
Directo	or	Usual Residence of Decedent	09				pan. 22	, 191/	IA		
yland	9	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d.	Inside City	
Mar-f st	호	MD Montgomer	ry		Gaithersh	ourg				1 Tyes	2 🔀 No
th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country	?	
23a	ia i	15116 Winesap Dr			208			United			
ire, Maryland 21215-0036 st end 2 should be filed within 72 hours after death with the Maryland st end 2 should be filed within 72 hours after death with the Maryland item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examination williad at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 	U.S. 13.	If Yes, specify Cuba	spanic Origin' n, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)		American k, White, etc Wh		
21215-0036 ad within 72 hours aff rgiene. ier then "natural", or it, the Medical Exami	edit	15. Decedent's Educ		16a, Dece	dent's Usual Occupa	ation		16b, Kind of Bu	siness/Indus	stry	
715 oin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	turing most of	working			,	
212 d with	E	12	College (1-401 5+)		Homemake	er		Own H	ome		
other	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Surname	e)		
/ar	70	David Campbell				E	mma Sell				
and and is mu	1	19a. Informant's Name/Relationship (Type		19h Maii	Address (Street a	and Number o	r Rural Route Numbe	er, City or Town, S	State, Zip Co	ode)	
end end lealth m 27		Cynthia J. Mellona		_	.6 Winesap	Drive	, Gaither:	sburg, M			
Baltimore, Maryland sermit. Pages 1 end 2 should be file Department of Health and Mental Hy mportant: If them 27 is marked oth eny injury or other traumatic event	N	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	matory or other place	θ) Jui	ne 5				
Iting It. Pa Itmer Itant	4	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Cemetery 2. Name and Addres			Wellsbur			
Baltimore permit. Pages 1 Department of H important: if its eny injury or ot	once	1 - 10	VER	De	er Park D	rive,	DeVol Fund Gaithersb	urg, MD	20877	East	
Pnysicia /Medic Examin	al er	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Acute m Due to (or as a cons Parkins	nyocardi equence of): on's di	al infaro					terval Betw nset and D	
8760, cate be executed physicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Carotid Due to (or as a cons	stenos	is						
.O. Box 6 the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of predictions of the second of the s	etal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date Mon	e of delivery oth Da	ay Y	'ear
rds, P quires that in signed b	۵	Part II. Other significant conditions con	tributing to death but not	esulting in the u	underlying cause give	en in Part I.		obacco use contri ∕es 2⊠No	ibute to the d 3 ☐ Probabl		
	Completed						24a. Was autop perio 1 □ Yes	rmed? d	Vere autopsy rior to compl eath? Yes 2	letion of ca	available ause of
of Vita Physicien: this certific	Be (25. Was case referred to medical					Death (Check only o				
Of V Physic Physic rathis c	ုင	1 195 2 X 140	ospital: 1 ☐ Inpatient 2				ng Home 5 ☐ Resid				
nding ath.	atlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time (Injury	Worl	/at k? Yes 2 ∐No		now injury occurre	ed		
우름다	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si ecify)	reet, factory, office		28f. Location (S City or Tov	Street and Number vn, State)	er or Rural R	loute Numb	ber.
ne Hoepitai n 24 hours e ne Funerel	edical		ician: To the best of my lier: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred at the time envestigation, in my of	ne, date and p pinion, death o	place, and due to the occurred at the time.	cause(s) and mai date and place, a	nner as state and due to th	ed. e cause(s)	,
To the within 2 the comple	N N	29h. Signature and title of certifier	1:2.7		29c. License	e number		29d. Date signed	(Month, Da	y, Year)	
43	3)	Wind 5	antimo		D4	1162		June 1,	2006		
5		30. Name and address of person who co Vinu Ganti, M.D.,			•	town.	MD 20874				
	State	31. Date filed (Month, Day, Year)									
	istrar	JUN 2 2	32. Posistrar's Sig	15 A	Market 1						

		1	For State Registrar	State of Ma	arylan		artment of H		and Me	-	iene	16	19284
			Decedent's Name (First, Middle	e, Last)						2. Date of Deat	h Day	Yeer	3. Time of Death
	Physicia /Medic		Lloyd	Rex	G	ray				JUNE 1			1958 ^M
	Examin	_	4a. Facility Name (If not institution				4b. City, Town, or	r Location of	of Death		4c. County		
			MEMORIAL HO		- "-		CUMBERL If Under 1 Year		24 Hre	0 Date -/ Dist	ALLE		
	Funeral Director		5. Social Security Number 233-46-1270	45711	9 (in yrs. i 78	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth Month, Day. Sep 13	· 1927	Gou	place (State or Foreign
			Usual Residence of Decedent								,		
	Marylan n-f ehow	ctor	MD 10a. State Alle	gany	10c. City	y, Town or Lo Cumb	perland						10d. Inside City Limits 1 X Yes 2 □ No
	h with the	al Director	10e. Street and Number 34 Virginia Ave	nue		*-	10f. Zip Code	21502	2	1	0g. Citizen of W		intry?
920	be filed within 72 hours after death with the Maryland and Hygiene. It hygiene do that then "natural", or iteme 23a or 28a-f show other, I're Medical Examinar must be notified at event, I're Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced				Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Ori an, Mexican Specify:	gin? (Spec a, Puerto P	city Yes or No- lican, etc.)	Blac	- Ameri k, White Whi	
21215-0036	within 72 ho ene. then "natur ne Medical	Completed		nt's Education st grade completed) College (1-4or 5	5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	eation during most d)	t of workin	g	16b. Kind of Bu		
C	be filed tat Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, James F. Gra							(First, Middle, M	naiden Sumam r) Gray	ө)	
Maryland	s 1 and 2 should f Health and Men Item 27 is marks other traumatic		19a Informant's Name/Relations Annie Myers	ship <i>(Турө, Print)</i> friend	b	19b Mailir 34 V	ng Address (Street Virginia Av	and Numbe 'enue	er or Rurai	Route Number Cumb	erland	State, Z	ວິ ^c ີ 21502
Baltimore,	Peges 1 and 3 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5		Res	lace of Dispo emetery, cree stlawn M	sition (Name of natory or other plac emorial Gar	dens		ate 6/16/2006	20c. Location -	City or T	own, State
Balti	permit. Peges Depertment of Important: If I eny Injury or once.		21. Signature of Funeral Service	DJ. Scar	all	~		ginia Av	enue:	Cumberl	and, MD 2	21502	2
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that caused tonly one cause on each i	the death	h. Do not ent	er the mode of dyin	ng, such as	cardiac or	respiratory arri	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Menin	. \ .	is							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							- 1
		-G	Sequentially list conditions,	b. Pheum	10()/	uence of).							scaus
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
0	cate be executed physicien and the burial-transit		resulting in death) Last	c. Due to (or as	a conseq	uence of):							
8760,	ste be nysicie he bu	Cai		d									
9	artifica ing ph e as ti	Med	IF FEMALE:										
.O. Box	thet the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	/			23d. Date Mor		rery Day Ye'ar
<u>α</u>	8 7 8	by Ph	Part II. Other significant conditi	_	out not res	ulting in the u	nderlying cause giv	en in Part I.					the cause of death?
ord	w require been si should t	ted	<u>Seizure</u>	2						1 U Ye	s 2 No	3∐Pro	bably 4 Dunknown
	The ete h page	Completed								24a. Was a autops perform	y ned? d		opsy findings available ompletion of cause of
/ita	Physician: Th this certificate ral director. pag	Be	25. Was case referred to medical examiner?	Manadal			104		of Death	Check only on	е)		
of	\$ in	ဥ	1 Yes 2 No	1 npatie		ER/Outpatier 28b. Time o		4 🗀 140			ence 6 Othe		fy)
no	After After fune	tion	1 Natural 5 ☐ Pendi		y Year)	Injury	Wor	k? Yes 2 □		od. Describe in	w injury occurr	5 u	
Division	il or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could 4 Homicide detern	not be	jury - At ho tc. (Specif	ome, farm, str y)	reet, factory, office		2	8f. Location (St City or Town	reet and Numbe n, State)	er or Rui	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	f examina	owledge, deat ition and/or in	h occurred at the tir vestigation, in my o	me, date an opinion, dea	d place, a th occurre	nd due to the ca d at the time, d	ause(s) and manate and place, a	nner as	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	H. Clut	aui		29c. Licens				9d. Date signed		**
			•	HOUSE		_	D58	853			JUNE 13	" 20	06
_	1		30. Name and address of person DR.HABIB CHOTA	NI 130 PENN	SYLVA	ANIA A	VENUE CU	MBERL	AND,	1ARYLANI	21502	2	
	Sta Registi		31. Date filed (Month, Day, Year JUN 1 9	2006 33 Registr	rar's Signa	ature	este						

State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 26, ^{Day}2006 **Physician** Philip Goodrich May 0807 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Y 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 11 M 2□ F 77 578-34-5859 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at X☐ Yes 2 ☐ No Directo Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S.A. 20853 "natural", or items 23a 4815 Tallahassee Ave. Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Insurance Agent Insurance injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem ZT is marked other principles in jury or other traumatic event gode. Rose Rosensky Goodrich Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4815 Tallahassee Ave. Rockville, MD 20853 19a. Informant's Name/Relationship (Type, Print) Frances L. Goodrich - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 5-29-06 Olney, MD Judean Mem. Garden 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service L 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine physician and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Non Hodgkins Lymphoma 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy morred 1 ☐ Yes 2 No 2X No After this certification or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2X ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospital or within 24 hours after death.

To the Funeral Director: Alt 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title l ce May 26, 2006 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Phillip Drive Olney, MD 20832 Joseph Kaplan, MD 1811 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 JUN Registrar

06-03596 Please Type or Print in Black Indelible Ink Charles Holbrook State of Maryland / Department of Health and Mental Hygiene 2006 19285 Certificate of Death Registrar 1 Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day May 27, 2006 Medical Examiner 1347 hrs Charles Holbrook Rav 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Cumberland Allegany 5 Social Security Number **Funeral** 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Kentucky Director Days Hours 405-92-9550 1 X M 04/09/1965 2 41 Country Yrs Usual Residence of Decedent any 10a. State 10c City, Town or Location 10d Inside City Limits 28a-f show Yes 2 XNo "natural", or items 23a or 28a-f sho Examiner must be notified at once. Allegany Cumberland hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 14601 Burbridge Road, SE 21502 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? Never Married 2 Married White, etc. Yes 2 X No Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify traumatic event, the Medical Examiner White Specify <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ should be filed within 72 and Mental Hygiene is marked other than MD 21215-0036 8 Handyman Marina 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Holbrook, Sr. Carolina ٥ 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Holbrook / uncle P.O. Box 45, Salyersville, Kentucky Pages 1 and 2 sl ment of Health ar Important: If item 27 injury or other trauma Baltimore, I permit. Pages I and Department of Healt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify Holbrook Fam. Cemetery 06/02/2006 Salversville, KY 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line /Medical Between Onset and Death a Acute Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical attending physician or use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 ✔ Unknown Completed icate has been si page 2 should b 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? After this certificate ✔ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death director, 25. Was case referred to medical 26 Place of Death (Check only one Be examiner? Hospital 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ို 1 V Yes No 28a. Date of Injury Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: (Month, Day, Year ✓ Natural 5 Pending Yes 2 No To the Funeral Director: completely filled in by the Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 28, 2006 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

Carol Allan, MD

31 Date filed (Month, Day, Year,

Assistant Medical Examiner

sistrar's Signature

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1515 Jean Emma Hammer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALLEGAN Braddock Canor 3MHSumberlai tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗸 F 65 Director 215-44-9117 10/08/1940 Maryland Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10b. County 10a State or 28a-f show ul Hygiene. other then "naturel", or tlems 23a or 28a-f shov vent, the Madical Examinar mast be notified at 1 ☐ Yes 2 No Director Mineral Ridgeley 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Route 2 Box 134 26753 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fits Department of Health and Mental hy Importent: if tiem 27 is marked oth any injury or other traumatic event 2008. Be William Mellott Emma Jeanette Hinton Howard ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose M. Luck / daughter P.O. Box 407, Ridgeley, West Virginia 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 06/07/2006 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatury of Fundral Service Licenses 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate triterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year **Physician** /Medical Due to (or as a consequence of): Examiner CD(UNEX-Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FFMALE If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 134362 615 who completed cause of death (Item 23a) (Type, Print) Name and address of per-900 SCTOP DRIVE Combelland, MD 21502 31. Date filed (Month, Day, State JUN 0 7 2006 Registrar

			- For Amend #19b, 6-1	State of Maryland / 12-06, per FHDR	Depa	rtment of H	ealth a Death	nd Menta	l Hygie	ene . No 2006	19288
	Physicia	an	1. Decedent's Name (First, Middle, Last)	owell				2. Dat	e of Death	Day Year	3. Time of Death 11:23A M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of	Death		4c. County of Deat	h
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	Funeral Director		197-24-3755	7. Age (In yrs. last b	Yrs.	Months Days	If Under 2 Hours	Min. (Mo	e of Birth nth, Day, Y	^{9. Birt} Co 1928 Pen	hplace (State or Foreign untry) nsylvania
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36	i 72 hours after death with the Maryland "natural", or Items 23a or 28s-1 show ofical Exprimer must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 XDivorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2☐XNo	n, Mexican, Specify:	Puerto Rican,	etc.)	Black, Whit	
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Maryland 21215-0036	\$ 5 E E		19a. Informant's Name/Relationship (Type Eileen Newburn/sis							City or Town, State, 20145	
ď	Pages 1 and 2 nent of Health a ant: if item 27 is ury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro			sition (Name of natory or other place		Date		Oc. Location - City or	
Itim	permit. Pag Depertment Important: I any injury c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lipense	Cnesa		e Cremato				ltsville, e P.O. B	
Ba	Depertit Imports any inj	1	Bove & X	MO1251	В	everly L.	Heck	rotte.	P.A.	Clarksvil	le, MD 21029
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Box.	The law requires thet the death certifica ste has been signed by the attending ph pege 2 should be detached for use es th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)	,			23d. Date ol de Month	livery Day Year
ds, P.O.	rires thet the signed by detacted	þ	Part II. Other significant conditions con	tributing to death but not resulting	g in the u	nderlying cause give	en in Part I.	23			o the cause of death?
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ono	frei	tlon:	27. Manner of Death Natural 5 Pending a Accident investigation	28a. Date ol Injury (Month, Day Year)	o. Time o Injury	Wor	k? Yes 2□!		9301100 1104	V Injury occurred	
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	Hospitel or 24 hours afte Funerel Dir itely filled in	lical C	29a. Certifier (Check only one) Certifying Physical Examination)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, deat and/or in	h occurred at the tir vestigation, in my o	me, date an pinion, deal	d place, and du th occurred at t	e to the car ne time, da	use(s) and manner a te and place, and du	s stated. s to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	lun		29c. Licens				d. Date signed (Mon	1
	. 2		30. Name and address of person who co	impleted cause of death (Item 23	а) (Тур <i>е</i> ,	Print)	. , /	-	1	une 3	10006
(2)	D-	ate	CIEMENT B. Kn	6hit M. J. 11 32. Resistrar's Signature	1065	Little	Patu	XENT F	Kwy	Columbia	MS 81044
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		For State of Maryla		artment of He			ene 0 0 6	19289
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physicia		William W. Hawki	ns			June 3	Day Year	8:00 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	
		228 Cobble Way		Walke:	rsville		Fred	erick
Funeral Director		5. Social Security Number 6. Sex 10 M 2 F 84	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) April 26	(ear) 9. Birti Co 5,1922 Ken	nplace (State or Foreign untry) tucky
P		Usual Residence of Decedent	a: =					
show	_		City, Town or Lo					10d. Inside City Limits 12 Yes 2 \(\bigcap\) No
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s 23	Funeral Director	228 Cobble Way 11. Marital Status 12. Was Decedent Ever in	11.5	2179		podu Vac ar Na	United St	
item item	ū	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 1 □ Never Married	or1d	Was Decedent of His If Yes, specify Cuban,	, Mexican, Puerto	Rican, etc.)	Black, White	
irs af	by	3 Widowed 4 Divorced Year or Dates: Wa:		1 ☐ Yes 2X No	Specify:		Specify: W	hite
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "natural", or Items 23a or 28a-1 show ent, the Medical Examiner must be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupati	ion	. 16	b. Kind of Business/l	ndustry
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Menta Menta Menta Menta Menta Menta Menta	2	Waverly W. Hawkins			Irene	Bailey		
2 should be and Mental is marked of aumatic even		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street an	nd Number or Rur	al Route Number, (City or Town, State, Z	ip Code)
and and bealth n 27		Maria Hawkins / Wife		Cobble Way				
of He	-	20a. Method of Disposition 1 ဩBurial 2 □ Cremation 3 □ Removal from State	 Place of Dispo cemetery, crei 	sition (Name of matory or other place))	Date 20	oc. Location - City or	Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens 1. Infern 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22				neral Hom	or and commented the control of the
3 80 5 8 8		Yourthey Stauffer					derick, M	0 21702
		23a, jart1 Inter the diseas of complications that fails 1 the disease, or heart failure. If tonly one cause on a filine.	eath. Do not ent	er the mode of dying,	such as cardiac	or respiratory arres	st,	Approximate Interval Between
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deatl	n occurred at the time	, date and place,	and due to the cau	se(s) and manner as	stated.
24 h 24 h e Fur	edical	(Check only 2 Medical Examiner: On the basis of examone) and manner stated.	ination and/or in	vestigation, in my opir	nion, death occur	red at the time, date	e and place, and due	to the cause(s)
o the compo	ĕ ≅	29b. Signature and title of Equifier		29c. License r	number	290	I. Date signed (Month	, Day, Year)
		Hos to Acon Koll	w) - 1	W Doo	58844	(MD)	6/06/0	6
MILL		30. Name and address of person who completed cause of death (tem 23a) (Type.	Print)	-00 11	110	412610	OF MANDEN M
J. 1		Jose Carpio	20400	Sene	eca M	leadous	PKUS 6	20876
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		•	For State Registrar	State of Maryla	-	rtment of H			giene 2006	19290
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and the second	Examin Funeral Director	ei	4a. Fácility Name (If not institution, give HOWORD (JVV) 5. Social Security Number 6. Social Security Number 1	GENERAL I	rs. last birthday) Yrs.	•	Lumbia If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	4c. County of Death HOWAK 9. Birthy Cour 0, 1950 Ma	
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc					10d. Inside City Limits
	ith the Ma or 28a-f	Director	Md Howard 10e. Street and Number		Colur	10f. Zip Code			10g. Citizen of What Cou	
936	be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other than "neturel", or items 23a or 28a-f show event, the Medical Examinal must be rediffed at	by Funeral	6107 Turnabo 11. Marital Status 1√2 Never Married 2□ Married 3□Widowed 4□Divorced	out Lane #4 12. Was Decedent Ever in Armed Forces? 1		21044 Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:	
21215-0036	within 72 houene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 10th Grade		(Give I	ent's Usual Occupi kind of work done of OO NOT use retired	during most of work)	ing	16b. Kind of Business/In	dustry
Q	2 should be filed withir and Mental Hygiene. Is marked other than surnatic event, the Mis	To Be C	17. Father's Name (First, Middle, Last) Charles Holl				Edna	Hard	Maiden Surname)	
re, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic engones.		19a. Informant's Name/Relationship (Crystal L. H 20a. Method of Disposition	arding-dau	gh 3442 D. Place of Dispos	Brinki	ey Ra,	al Route Numbe #402 T Date	r, City or Town, State, Zip emple Hill 20c. Location - City or To	Ls, Md
Baltimore,	permit. Page Department Important: If ony injury or once.	4	1 Surial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service) Licer 23a. Part1. Enter the disease, or com	Gu Gu	, 22	Name and Addres			P.A. 208	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.	eath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory and	rest,	Approximate Interval Between Onset and Death
8760,	/Medical Examiner hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	LITUS				
P.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
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	£ ₹ ₽ Ø		29b. Signature and title of certifier	Treedma	۸.,	H3	7211		MAY 30	2006
/ 🍱			30. Name and address of person who MARNALL FRA 31. Date filed (Month, Day, Year)	completed cause of death (150 KN	-	COLUM	BIA, 1	ND 2109	15
	St Regist	ate rar		106 Reduced	St. Spe	ales)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ELIZABETH ELLEN HEFLIN MAY 30, 2006 7:38 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K I F 80 Director 578-22-1918 MARCH 22, 1926 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND MONTCOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 238 1200 SPOTSWOOD DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 TYes 2 X No. Specify Specify à 3 Widowed 4 Divorced WHITE natural', Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MONTGOMERY COUNTY than Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY BOARD OF EDUCATION 12 and Mental Hygin is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALFRED GIDDINGS ပ္ ELSIE LAIZEAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ERNEST L. HEFLIN / HUSBAND 1200 SPOTSWOOD DRIVE, SILVER SPRING, MARYLAND 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: if it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKLAWN CEMETERY 4 □ Donation 5 □ Other (Specify) JUNE 5, 2006 ROCKVILLE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Lic HINES-RINALDI FUNERAL HOME 200 11800 NEW HAMFSHIKE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION 24 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) nding physicien Box 68760 by Physician/Medical use as the IF FEMALE If yes, oulcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RENAL INSUFFICIANCY : certificate ANEMIA 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 🔲 Inpatient 2 X ER/Outpatient 3 DOA ieral Director: After th filled in by the funeral 27 Manner of Death 28a. Dale of Injury (Month, Day Year) 28c. Injury al Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35112 MAY 30, 2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, MD Paul B. Baker, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Come JUN 5 2005 Registrar

			For State Registrar	State o	f Marylar	•		nt of He te of D		and Me	ental l	⊣ygie _{Reg}	60	06	19292
			Decedent's Name (First, Middle, Last)								2. Date of		-		3. Time of Death
н	Physici		Kui Hong Soo H	00							Month June	_	Day 2006	Year	4:00 a M
	/Medic Examin		4a. Facility Name (If not institution, give si	reet and nur	nber)		4b. City	, Town, or	Location o	of Death	ounc		4c. County	ol Death	1 4.00
	LAGITIII	C.	Holy Cross Hospit	a I			Si	lver	Spri	na			Mont	gome	P17
	Funeral		5. Social Security Number 6. Sex	aı .	7. Age (In yrs.	last birthday)	II Unde	r 1 Year	If Under:	24 Hrs.	8. Date o	f Birth		9. Birthp	lace (State or Foreign
	Director		052-20-0297	M 2□F	83	Yrs.	Months	Days	Hours	Min.		, Day, Y 21,	1923	Cour	nina
	ס		Usual Residence of Decedent												
	how how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside City Limits
	a Ma	cto	Maryland Montgom	ery	Sil	ver Spi	ring								1 ☐ Yes 23€ No
	or 28	Directo	10e. Street and Number				10f. Zi	p Code				10g	. Citizen ol 1	What Cour	ntry?
	death with the Maryland me 23a or 28e-f ehow count be polified at		10101 Leder Road				20	902					U	SA	
	dea Fe	Funeral	11. Marital Status	2. Was Dece Armed Fo	edent Ever in U		Was Dece	dent of His	spanic Ori	gin? (Spec	orty Yes o	r No-		e - Americk, White,	can Indian, etc.
ထ္	or it	F	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv			1 ☐ Yes	2 🔀 No	Specify:					Asian	
ğ	within 72 hours after ene. than "neturel", or ite he Medical Example	d by	3 ☑ Widowed 4 □ Divorced	Year or D	ates:										
ζ.	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Dece (Give	kind of w	ial Occupa ork done d use retired,	luring most	t of workin	g	16	b. Kind of B	usiness/In	dustry
2	Athir ne.	ш	Elementary/Secondary (0-12) 12	College (1	I-4or 5+)								Д-	_+	
2	filed v Hygie Sther t		17. Father's Name (First, Middle, Last)			D	usine	ss Ov		r's Name	(First Mic	ddle Ma	iden Suman	stauı	rant
Maryland 21215-0036	m 0 -	Be	Quong Soo Hoo							Nui [30.0, 11.0		,	
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<u>a</u>	12 st h and 7 te n treun		19a. Informant's Name/Relationship (Typ	e, Fintj		1							322	8223	
ຜົ	1 and dealt	1	Frank Soo Hoo/ Son 20a. Method of Disposition	A	20b.	16516 Place of Dispo			Washi		n Dri		c. Location -		MD 20853
ō	10 mg		1 Surial 2 ☐ Cremation 3 ☐ Re	moval from	State	cemetery, crei	natory or	other place		June	6,			•	
altimore,	T T T T T		4 Donation 5 Other (Specify)		Gat	e of Hea				200					ng,Maryland
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked eny Injury or other treumatic en ance.		21. Signature of Funeral Service License The head L Acles										Home Lver S		g, MD 20901
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that o	aused the dea	th. Do not ent	er the mo	de ol dying	g, such as	cardiac or	respirato	ry arrest			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			_									Onset and Death
	/Medical		resulting in death)	Cerek Due to	or as a conse	ular Ac quence ol):	cide	nt -							12 Hours
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9	ng pt	Med	IF FEMALE:												
Вох	Physicien: The law requires that the death certific this certificete hes been signed by the attending prial director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant		come of pregn pirth 2 Fet]Ectopic p	regnancy						te ol delive	,
Ш	ed fo	SICI	in the past 12 months?	4∐Pregr 9∐Unkn	nant at time of	death 5	Other (s	pecify)					IVIC	ини	Day Year
<u>Р</u> .	that the de- led by the a detached f	h.	9 Unknown										1		
Ś	w requires that been signed to should be det	۾	Part II. Other significant conditions con	inbuting to a	eath but not re	sulting in the u	nderlying	cause give	n in Part I.	•					ne cause of death?
Ž	equir sen s	ted	Aspiration Pnuemon	itis								Yes	2 L No	3 Prot	pably 4 Unknown
BCC	law r es be 2 sh	pie									a	Mas an autopsy	1	prior to co	psy lindings available mpletion of cause of
Œ	The ete h page	Completed									1 \ Y	erforme es 218	d? I No	death?	2 No
Ħ	ien: artific ctor,	Be (25. Was case referred to medical examiner?						26. Place	ol Death	(Check o	nly one)			
<u>_</u>	nysic lidire	٥	1 ☑ Yes 2 ☐ No	ospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	OA Othe	er: 4 □ Nu	ırsing Hom	ne 5⊡F	Residenc	ce 6 □Oth	er (Specif	y)
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Ξ	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	of Injury - At h	nome, farm, sti	reet, facto	ry, office		2	8f. Locati City o	on (Street Town, :	et and Numb State)	oer or Rura	al Route Number,
	ital or irs efte rei Dir														
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	er: On the b											
	vithin of the	Me	29b. Signature and title of certifier				25	c. License	number				. Date signe		Day, Year)
			Peter 5-B	wk.	M.D.		1	2001	506			0	6/01/	106	
•	20		30. Name and address of person who co			m 23a) (Tvne									-
			Peter S. Birk, M.D	. 108	329 Geo:	rgia Av	renue		2, Si	lver	Spri	ng,	Md 20	902	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 5 21	32. 32.	gistrar's Sign	S. A	parti	P							

			1 - For State Registrar	State of M	larylar				ealth a			Reg. N	ZUUD	19293
	Physici	an	Decedent's Name (First, Middle, Las								Date of De. Month	D	ay Year	3. Time of Death
	/Medic	al	David 4a. Facility Name (If not institution, give	Kogon	-1		45 035	T	Location of		May 28		006	9:40 A ^M
+	Examin	er	Montgomery General				'		Location	or Death		4	c. County of Dea	
	Funeral					last birthday)		r 1 Year	If Under		8. Date of Birt	th	Montgon 9. Bi	nery httplace (State or Foreign ountry)
ve. E.	Director		579-40-6547	∑M 2□F	91	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 2		1914	New York
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Aaryle f eho	ŏ												1 XYes 2 No
	the the route	rect	MD Montgome 10e. Street and Number	ery		Silver		ing p Code				10a. C	itizen of What C	ountry?
	h with	Funeral Director	3701 International	l Drive.	#509			2090	6			Πτ	nited St	ates
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	I.S. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am- Black, Whi	erican Indian,
36	or its	y Fu	1 Never Married 2 Married	Yes Give	^{∣No} Nav	У	1 🗆 Yes		Specify:	,, , , , , , , , , , , , , , , , , , , ,			Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow re Modical Examinat man be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates	WW II	16a. Dece	dont's He	al Occupi	ation			16h		Andreas .
<u></u>	in 72	Completed	(Specify only highest gra-	de completed)	<i>a</i>)	(Give	kind of w	ork done d use retired	luring mos.	t of workir	ng .	100.1	Kind of Business	vindustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	Sta	tist	ician					Federal	Government
ם	e file al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,	Maide		OWY CITIME! IL
<u>yla</u>	Duid b Ment arked atic e	To	Sam Kogon								iparsky			
Maryland	permit. Pages 1 and 2 should be itled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show any Injury or other traumatic event, the Modical Examinating matter footfied at once.		19a. Informant's Name/Relationship (7										or Town, State,	
e,	1 and Health em 27 ther t		Maurice Kogon - Sc 20a. Method of Disposition)11	20b. I	4∠10			treet		rrance,		aliforni Location - City or	
Baltimore,	S T T OF		1 Surial 2 ☐ Cremation 3 ☐			unt Le	natory or	other plac	θ)		1-2006		delphi,	
Ħ	ertme ortani Injury		4 ☐Donation 5 ☐ Other (Specify 21. Signature of Funeral Service ☐eth			22	2. Name a	nd Addres	s of Facilit				,	
Ba	Dep men		1		3	D.	anzar	ısky-	Go1db	erg			Chapels	
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	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	luence of):								
	xecul and al-trar	xan	that initiated events resulting in death) Last	c Due to (or a:	s a consec	uence of):								
8760,	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.			d										
9	tificat ig phy as the	Physician/Medical												
Вох	res that the death certific igned by the attending p be detached for use as	an/N	230. Was decedent pregnant	23c. If yes, outcom- 1 ☐ Live birth			Tectonic c	regnancy					23d. Date of de	,
	e dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant a 9☐ Unknown			Other (s						Month	Day Year
O.	hat the		Part II. Dther significant conditions or	ontributing to death	but not rec	culting in the u	ndorhina	20100 0110	o io Part I		22a Did to	bacco	uca contributa t	o the cause of death?
Division of Vital Records,	signe d be d	d by	Colon C		Dat not 10s	anting in the di	indenying i	Jause give	ariaria≔eutt.					robably 4 Unknown
Ö	v requir been si should	Completed									-			
Re	he lay	dmo									24a. Was autop perfo		prior to death?	utopsy findings available completion of cause of
tal	an: T tificet tor, pe	0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	2 💢 N	o 1 Yes	2 No
<u> </u>	nysician: The Is us certificate he director, page 2	ToB	examiner?	Hospital:	ent 2	ER/Outpatien	nt 3 D	Othe	NP-				6 ☐Other (Spe	icity)
0	ding Physin. After this funeral di	L:uc	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D.	ury ay Year)	28b. Time of Injury		28c. Injury Work			8d. Describe h			//
Sio.	r Attendii er death. rector: A by the fu	catic	2 Accident investigation				М		res 2 🗆 l	No				
<u>\<u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u></u>	or Atl	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At h itc. (Specia	ome, farm, str fy)	eet, factor	y, office		2	8f. Location (S City or Tow			ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	O	29a. Certifier 1 X Certifying Phy	/sician: To the bes	t of my key	awledge dest	2 000	l at the t	o dot	d pla	ad dua to th			
	24 hc 24 hc Fun etely	edicai	(Check only 2 Medical Exam	iner: On the basis	or examina	ation and/or inv	vestigation	n, in my op	e, date an	d place, a th occurre	d at the time,	date an	s) and manner as id place, and due	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	ate signed (Mont	h, Day, Year)
	20		Frank 1.	sh cu	, m	0	ת	23630)			Tun	e 1, 200)6
			30. Name and address of person who d	ompleted cause of	death (Iter	n 23a) (Type,						Juil	۷۱۱ و ۱ ح	,,
			Frank J. Mayo				Road	#213	Gait	herst	ourg MD	20	877	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7	32. Jegist	rar's Signa	ture do	ale	,						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Yoram J Kaufma		1- For State Registrar	State of Maryl		oartment o e <i>rtificate o</i>		and N	1ental F	, 5	Reg. No 2	006 1929
Physicia Medical Examin	n/ ier	Decedent's Name (First, Mic Y	oram Janus		MAN		_	-	2. Date of De Month May 31,	ath Day Yea	3. Time of Death 1805 hrs
Y		4a. Facility Name (if not institute Prince George's Hos		umber)		4b. City, Tov		ation of Dear	th	4c. County of Prince G	
Funeral Director		5. Social Security Number 220-92-8025	6. Sex	7. Age (In yrs	s. last birthday) 7 Yrs	If Under Months	1 Year If	Under 24Hi Hours Mi	rs. 8. Date of B	irth(MM/DD/YYYY 1, 1948	9 Birthplace (State or Foreign Country Poland
nd show any ee.		Usual Residence of Decedent 10a. State 10b. Count Maryland Mont	gomery		ty, Town or Loca						10d Inside City Limits 1 Yes 2 No
with the Maryland s 23a or 28a-f show a	Direct	10e. Street and Number 13114 Broadm				10f. Zip Co	0904			10g. Citizen of Wr	nat Country?
r death v	by Funeral		Married Armed F 1 Yes IVOrced If Yes, Give Ye or Dates	2 X No	If \	as Decedent Yes, specify (Cuban, Me	xican, Puert	Specify Yes or N o Rican, etc.)	White Specify	white
s, MD 21215-0036 and 2 should be filed within 12 hours after lealth and Mental Hygiene tem 27 is marked other than "natural", trammatic event, the Medical Examiner	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12	College (1-4 or 5+)		nt's Usual Oc nost of workin	ng life, DO	NOT use re	tired)	Atmosph Physics	neric S
e, MD 21215-0036 I and 2 should be filed within 7 Health and Menial Hygiene item 27 is marked other than rtrammatic event, the Medica	<u>a</u> [17. Father's Name (First, Middl A 19a. Informant's Name/Relation	natol Kauf	man	19b Mailin	a Address		Balka	a Bergma		n, State, Zip Code)
nore, MD 2 ages I and 2 shou rut of Health and I nt: If item 27 is r	<u>-</u>	Jean Kaufman, 20a. Method of Disposition		20b		Broad	lmore	Road		r Spring,	
imore Pages I ment of It		1 X Burial 2 Crematic 4 Donation 5 Other 21. Signature of Funking Service	Specify:	rom State	crematory or of udean Me	ther place)	l Gar	dens	06/04/0	Olney	
Physician Physician Physician		23a. Part I. Enter the disease, of	1) caused the dea	25	4 Carı	011	St. 1	Funera.	nington	DC 20012 art Approximate Interval
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cuted nnd transit	al Examiner	(Disease or injury that initiated events resulting in death) Last		a consequence	e of)						
60, rate be executed obysician and	Medical	UNPENDED IF FEMALE:	230. II yes,	, 28 c . 28	f perMF.6	/14/06,1	EMW.Mo	Ch		23d. Date of	delivery
m ⊕ ⊗ ⊕ l	hysiciar	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	nknown 9 Unkr	nant at time of	death 5 0	etal death ther (Specify)	ctopic pregn	ancy	Month	Day Year
S, P.O. Bc pures that the dee	leted by P	Part II. Other significant cond	itions contributing t	to death but no	t resulting in the	underlying ca	use given	ın Part I.	1 Ye	s 2 No 3	bute to the cause of death? Probably 4 Unknown
Reco The law cate has	Somp								1 Yes	psy p	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
Vital I hysician: this certifi	Ö	25 Was case referred to medic examiner? 1 ✓ Yes 2 No	Massital:	Inpatient 2	ER/Outpotion		Otho	eath (Check	ng Home 5	Residence 6	Other:
sion of Vit stending Physic death ttor: After this s y the funeral dire	cation: T		nding May 26 estigation	e of Injury h, Day Year) , 2006	28b. Time of 1544 hrs	1	Injury at \	2 No-		how injury occurre uck by vehicle	
Divisior Hospital or Attené 14 hours after death Funeral Director: tely filled in by the	Sertifi	3 Suicide 6 Co	uld not be 28e. Plac	ce of Injury - At Local Str	home, farm, stre	et, factory, of	fice buildin	ig, etc	28f. Location (or Town, S Soil Conse	Street and Numbe State)Greenb vation Road (r or Rural Route Number, City Delt MD © Explorer Road, Creen
To the Ho within 24 P To the Fu	edical	one) Medical Ex	Physician: To the be aminer: On the basis and manner:	of examination							
15		29b. Signature and title of cegin	dens				cense nun			June 1, 200	d (Month, Day, Year) 06
			Assistant Medica		_	Street, B	altimore	e, MD 212	201		
Sta Regist	ate	31. Date filed (Month, Day, Year UN 2	2006 32.	gistrar's Signa	atura Ago	W)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day **Physician** 3, Pauline 7:35 PM Kippen June 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Catherines Nursing Center Emittsburg Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F 513-09-7448 Director 86 Dec.19,1919 Russia Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumstic event, the Medical Examinar must be notified at Maryland Frederick 1 Yes 2 No Emittsburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code St. Catherines Nursing Center 21727 **USA** death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Ite Yes 2000 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Secretary Doctors Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John George Boxberger Magdalena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8139 Claiborne Drive, Frederick, MD 21704 John Kippen/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or 6/6/06 Stauffer Crematory * 4 □ Donation 5 □ Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 e or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or fleart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a) as a consequence of): Examiner burial-transit certificate be executed Q Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 → No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0 the should be detached 9 Unknown 9 Unknow been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2**X** No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1X Natural after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Seton Drive, Emmitsburg, MD 21727 Alan Carroll gistrar's Signature 31. Date filed (Mont State 0 6 2006 Registrar

			For State Registrar	State of Maryland	•	nt of Health and lete of Death		iene g. No. 2 () () ()	19296
			Decedent's Name (First, Middle, Last)				2. Date of Deat	1	3. Time of Death
	Physici		Marcus	Lee	Laza	rus, Jr.	Month	Day, Year	12015 M
1	/Medic		4a. Fecility Name (If not institution, give s			, Town, or Location of Deat	h	4c. County of Deat	h
	Examin	er	WMHS-Brag	dock Cam	0115 (umber	and	allea	anix
Ξ	Funeral		Sociat Security Number 6. Sex	7. Age (In yrs. last	Months	Year If Under 24 Hrs Days Hours Min.		Year) 9. Firt	hplace (State or Foreign untry)
	Director		216-18-1299	M 2□F 85	Yrs.	Days Hours Him.	04/24/1	921 Mar	yland
	2 3		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Location				10d. tnside City Limits
	aryla Pho	ا م				1 1 1			1 XYes 2 No
	788-f	Director	MD A11e	gany		mberland pCode	10	og. Citizen of What Co	untry?
	with		12 S. Lee S	Street	101.2	21502		USA	
	filed within 72 hours after deeth with the Maryland Hygiene. ther then "natural", or flama 23a or 28a-f ahow ant, the Madical Examinar must be notified at	Funeral		2. Was Decedent Ever in U.S.	13. Was Deci		Specify Yes or No-	14. Race - Ame	rican Indian,
	ter d	Ξ	1 ☐ Never Married 2 ☒ Married	Amed Forces?	_	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
200	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	tt Yes, Give 1945 Year or Dates: 1946	1 102	21 No Specify:		Specify: W1	nite
Ş	2 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation 1	6a. Decedent's Us	ual Occupation ork done during most of wo	deina	16b. Kind of Business/	
77	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	9		
7	y gien	ő	12		Owner and	l Operator		Retail	
ם	be file	Be	17. Father's Name (First, Middle, Last)				me (First, Middle, M		
Maryland 21215-0036	should ind Men in marke umatic	ဥ	Marcus		zarus, Si			Kusı	
<u>a</u>	2 sh and Is m		19a. Informant's Name/Relationship (Typ	•		s (Street and Number or Ri			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or itama 23a or 28a-f ahow any injury or other traumatic avant, the Madical Examination and itled at ance.		Lina Reinert / da 20a. Method of Disposition		e of Disposition (Na	stow Circle,		VITGITIA	20147 Town State
Baltimore,	Pages nent of h int: If its ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	etery, crematory or	other place)			
	it. Partitude ritant ritant		4 □Donation 5 □ Other (Specify) 21. Signature of Furnial Service License		Hill Cen			Cumberland	
Ba	permit. Departr Importa		21. Signature pri i di lai Service Elcense		1	and Address of Facility Ad Decatur Stree			21502
			23a. Part1. Enter the disease, or compli	cations that caused the death.					Approximate
			shock, or heart failure. List only on tmmediate Cause (Final	e cause on each line.		. /			triterval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen		luce			3 days
	Examiner			Sacio	100 01/.				5 days
	_	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to for as a consequen	nce of):				7:
	outed ansit	Examiner	Cause (Disease or injury that initiated events						
o	a exercian ar		resulting in death) Last	Due to (or as a consequent	nce of):				
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical							
39	ing pl	Med	IF FEMALE:	St. Water-Schule	-010 AT L-20	W-12-)		
Вох	eath certific attending p for use as 1	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 Ectopic			23d. Date of del Month	ivery Day Year
_ o		Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of deat 9 ☐ Unknown	h 5 ☐ Other (s	specпy)			
<u>Ф</u>	thet the deed by the detached	P.	Part It, Other significant conditions con	itnbuting to death but not resulting	ng in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	8 8 9	d by	Chronic Fidnes Dispo	et Co			1 □ Ye	s 2.⊒No 3 □ Pr	obably 4 Unknown
Š	> 11 0	ete	Dad				24a. Was a	24b Were au	itopsy findings available
of Vital Records,	e la hes	Completed	Im KINIME ? DIZE	as a			autops perform	prior to death?	completion of cause of
a	rician: Th certificete rector, pag	C	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2 ath (Check only on	Yes	21 No
5	Physician: this certific ral director.	To B	examiner?	lospital: 1 Inpatient 2 ER	VOutpatient 3 0	Other		nce 6 □Other (Spe	cifv)
o	g Phys er this eral di		27. Manner of Death		Bb. Time of Injury	28c. Injury at Work?	28d. Describe ho		
0	Attending r death. actor: After by the funer	atio	1. ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Bay Your)	М	1 ☐ Yes 2 ☐ No			
Division	or Attendated after death Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At home building, etc. (Specify)	e, farm, street, tacto	ry, office	28t. Location (St. City or Town	reet and Number or Ru , State)	ural Route Number,
ā	ital or its after								
	a Hospital 24 hours a a Funeral letely filled	edicai	(Check only 2 Medical Exemi	sician: To the best of my knowle ner: On the basis of examination					
	ਦ 등 ਦੇ ਨ	Med	one) 29b. Signature and title of certifier	and manner stated.	2	9c. License number	2	9d. Date signed (Mont	h, Day, Year)
	5 × 5 × 6	_	1/2-1) Ne		DOS FREE-	. -	Calada.	
	IUA		30 Name and address at the same	ompleted cause of death (the 2)	3a) (Type Briet)	DUS 774-1		0/4/00	9
1	LLI		30. Name and address of person who co	Service Canada of death (fleth 5:		SIG GOTS	ive Cun	nberlain	, ND 21205
	St	ate	31. Date filed (Month, Day, Year)	32. Degistrar's Signatur		- 101			
	Regist		INN 0 7 200	6 Brens K	hours	,			

DHMH 17 Rev 1/2001

ORIGINAL

		1- For State of Maryland / Dep State RegistrarAMEND#11perFH6/2/06, EMW, MCCo	partment of Health and Nertificate of Death	Mental Hygie	2007 1000
		1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
Phys /Me	iciar dica	Robert Lee Langley		May 26	, 2006 2345 M
Exan	ninei	4a. Facility Name (If not institution, give street and number) Prince George's Hospital	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George
		5 Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
Funer Directe		245-56-4608 1½M 2□F 66 Yrs.	Months Days Hours Min.	8. Date of Birth (Month Day Ye 12/9/39	(Country)
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
faryla star	è				1 AYes 2 No
the A	Director	10e, Street and Number	10f. Zip Code	10g.	Citizen of What Country?
h with	2	1708 Brightseat Road	20785		USA
be filed within 72 hours after death with the Maryland tall tygiene. And other than "natural", or itema 23a or 28a-f show event, the Majical Exatta arminates notified a	Finaço	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 \(\text{Nover Married} \) 13	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: Black
72 hours "natural",	À		edent's Usual Occupation	161	. Kind of Business/Industry
in 72 in mater	potologic	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin life	re kind of work done during most of work DO NOT use retired)	ring 100	·
e filed within al Hygiene.	1	Elementary/Secondary (0·12) College (1-4or 5+) L L	abor		Private
al Hyg	9	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai Matthew	· ·
2 should be and Mental is marked raumatic ev	F	Domi Flank Bangley			
Mar 12 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) Robert Lee Langley Jr Son 1708	lling Address (Street and Number or Rui Brightseat Rd		
DAILLIMOTE, INITIYIAT permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic ex		20a Method of Disposition 20b. Place of Dis	position (Name of		Location - City or Town, State
altimor	B	1 🔀 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryla	ematory or other place) nd Veterans 6/5	/06 Ch	eltenham,MD
milt. I	8	21. Signature of Funeral Service Licensee			uary Service, P.A
2 88 5	8				Bowie, Maryland Approximate 21
	X	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between Onset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)			
Examin	_	Due to (of as a consequence of):			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/ , .		
8 / 6U, ate be executed obysicien and the burial-transit	1	that initiated events	nary fistula		
oe exe cian a vurial:		resulting in death) Last Due to (or as a consequence of):	0 0		
OX OS (DU, certificate be executed nding physician and use as the burial-transit		d			
BOX 68 leath certifica attending ph	100	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown			23d. Date of delivery
. 0 0 9	19	in the past 12 menths? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
at the U by the Blache		9 Unknown			
	3	2	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Únknown
ecords, law requires t las been signe	1			24a. Was an	
e lay				autopsy performed	
		25. Was case referred to medical	26. Place of Dea	1 Yes 2 th (Check only one)	No 1 ☐ Yes 2 ☐ No
	1 1	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpate	Othon		e 6 ☐ Other (Specify)
On OT ding Phy h. After this funeral d			Work?	28d. Describe how i	njury occurred
ISIOF Nttendin death. ctor: Aff	3	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Street	t and Number or Rural Route Number,
DIVISION If or Attending after death. I Director: Afte		27. Manner of Death 2 Accident 5 Pending 2 Accident Injury 28a. Date of Injury 28b. Time 28a. Date of Injury 28b. Time 28b. T	street, factory, office	City or Town, S	tate)
Hospite 4 hours Funeral		29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.			
within 2	-	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
4 (+	V	1 with	D58957		5/31/04
7		30. Name and address of berson who completed cause of death (Item 23a) (Typ		Chever	1, m1 20186
3 Trans.	State	31. Date filed (Month, Day, Year) JUN 2 2006 32. Registrar's Signature	garles		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate of	Death			Re	eg. No.	20	06 1929
Physicia Medical Exami		1. Decedent's Name (First, Midd Timothy Randal							Date of Deal Month une 9, 20	Dav	Year	3. Time of Death 1224 hrs
		4a. Facility Name (if not institution		ımber)	4	1b. City, Town, o	r Location o		une 9, 20	4c. (County of De	eath
- Andrews		7 Clybourne Court 5. Social Security Number	6. Sex	7. Age (In yrs. la	ant hirthday)	Towson	on It I to do	n 0414m 0	Data of Div		altimore C	
Funeral Director	1	099-68-1284	1X M 2 F		22 Yrs.	Months Da		Min.			Fo	Birthplace (State or reign
		Usual Residence of Decedent							May 2,	198	54	Country) New York
w any		10a. State 10b. County		,	Town or Locati	on						10d. Inside City Limits
Maryland 28a-f show d at once.	ţġ	Maryland Howard	d	Colu	mbia	10f. Zip Code			11	On Citize	en of What C	1 Yes 2 No
r death with the Maryland or Items 23s or 28s-f sho must be notified at once.	Director	10041 Cape Ann	Drive			21046				USA	sir or vviiat c	south y?
th with	uneral	11. Marital Status 1 X Never Married 2 N		edent Ever in U.	S. 13. Wa	s Decedent of Hi es, specify Cuba	ispanic Origi	in? (Specif	y Yes or No	- 1	4. Race - Ar White, etc	merican Indian, Black,
ter dear	ш		1 Yes	2 X No		Yes 2X No		T GC/10 T GC	an, etc./		ipecify: W	
ours af atural	d b	15. Decedent's Education (Spe	or Dates:		16a. Deceden	t's Usual Occupa	tion (Give k	and of work	done		nd of Busine	
36 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)		ost of working life		use retired)		II.		
d with ygiene other the	E O	17. Father's Name (First, Middle		<u></u>]	rnysic	al Trai		s Name (Fir	st, Middle, N			ty Gym
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than tite event, the Medica	Be	Larry Brian La					Carol	Jean	Sope	r	,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relations L. Brian Lawren				Address (Stre						
e, N and 2 Health item 2 r traus	Ì	20a. Method of Disposition		20b. F		tion (Name of ce			ate			or Town, State
Baltimore, permit. Pages I ar Department of Het Important: If ite		1 Burial 2 X Crematio 4 Donation 5 Other S		om otate			ory-	06/13	1/06	Be1	tsvil'	le, Maryland
Balti Sermit. Departi Import	Ī	21. Signature of Funeral Service			22. N Go	ame and Addres	s of Facility	ation	Serv	ice	P.O.	Box 784
Physician	-	23a. Part I. Enter the disease, o	r complications that ca	MO1	Do not enter th	verly I. e mode of dying	Heck , such as ca	rotte	P A	C1	arksvi k. or heart	L11e MD 2102
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	e on each line.	(Morphin							,	Between Onset and Death
Adminer	-	or condition resulting in death)		consequence of):							
	je.	Sequentially list conditions, if any, leading to immediate		consequence of):					_	_	
	/Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):							
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ian ian	edic	Xunpended	AMENDED		<u> </u>	,perME,g8	56,6/30)/06 TT	1			
		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		outcome of pregr irth		al death 3	Ectopic	pregnancy			Date of deliving	very Day Year
Box 68760, death certificate be the attending physical for use as the but	Physician		4 Pregna	ant at time of dea	nt lo	er (Specify)		-				
that the d ned by the		Part II. Other significant condi			sulting in the u	nderlying cause	given in Par	t I.	23e. Did to	bacco us	e contribute	to the cause of death?
S, P.	ed by				<u> </u>				1 Yes	2 🗸	No 3 P	Probably 4 Unknown
ords aw requii as been a	Completed						_	[24a. Was a autops	sy	prior t	autopsy findings available to completion of cause of
tal Rec	틼								perfor 1 V Yes 2	med? 2 No	death 1	
Vital ysician: his certifi director,	BB	25. Was case referred to medica examiner?	Hospital:	npatient 2	ER/Outpatient		Other	Check only Nursing Ho		Pooldona	e 6 ✔ Ot	how Coope
n of V ding Phy After th funeral d	읽	1 Yes 2 No 27. Manner of Death	28a. Date of		28b. Time of In		ry at Work?		. Describe h			ner: Scene
ision Attendi	Įį.				Fnd 12:15	pm 1	Yes 2 X	No unl	known			
.≥ 호쓸 등 [Certification:	dete	ermined (Specify)	e of Injury - At ho	me, farm, stree residenc	•	ouilding, etc.	. 28f.	Location (S or Town, St	treet and	Number or Lybourn	Rural Route Number, City De Court
Inospital 24 hours: Funeral stely filled		29a Cartifier	hysician: To the best			_	ate and plac					
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exa	miner:On the basis o	of examination an								
	Σ	29b. Signature and title of certific	fr / //			29c. Licens						Month, Day, Year)
	ķ	30. N be an ad ress of person	who compet agus	e of death /Itam	23a)	O.C.	IVI.⊏.			June	10, 2006	
(5)00		Susan Hogan MD.	Assistant Medica	•	·	Street, Balt	timore, M	ID 21201				7.
Sta Regist	ite	31. Date filed (Month, Day Year)	4 2008 32. Reg	etrar's Signatur	et An	and a						
Regist	CII.	0011 1	- T C000		1650	arte						

		_	1 - For State Registrar		ryland / Depa		Health and	Mental Hyg	,	006	192	299
	Physici	an	1. Decedent's Name (First, Middle, La Pauline M. Long	st)				June 2,	2006	Year	3. Time of I	
	/Medic	al	4a. Facility Name (If not institution, giv	e street and number)		4h City Town	or Location of Deat			nty of Death	10:05	Ам
	Examir	er	11945 Bambi Cour			Gaither		, ,		gomer		
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birth		0.014	place (State or ntry)	Foreign
	Director		Usual Residence of Decedent		/9 Yrs.			June 26	, 1926	Eng	land	
	how		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City	
	Ba-f	ecto	Maryland Montgome	ry	Gaither						1 🗍 Yes	2 X No
	With t	Funeral Director	10e. Street and Number 11945 Bambi Cour	t		10f. Zip Code 20878	₹		10g. Citizen o United		-	
	deeth	nera	11. Marital Status	12. Was Decedent E- Armed Forces?	ver in U.S. 13.		Hispanic Origin? (S an, Mexican, Puer			ace - Ameri	can Indian,	
36	filed within 72 hours after deeth with the Maryland Hygiene. yther then "natural", or iteme 23a or 28a-f ehow wit, the Medical Examiner must be mailfied at	by Fu	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No	0	i res, specify cub i ☐ Yes 2 🛣 No		to Alcan, e(c.)	Spec	lack, White,		
Maryland 21215-0036	2 hour	ted b	15. Decedent's E	Year or Dates: ducation	16a. Dece	ient's Usual Occup	pation		16b. Kind of	Wh	ite	
215	thin 72 en "na Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+	(Give	kind of work done OO NOT use retire	during most of wo d)	rking			,	
7	lled wi lygien ther th	CO	12 17. Father's Name (First, Middle, Last	-	Homer	naker	19 Mothada Na	me (First, Middle,	Own H			
auc	id be f ental } ked of	To Be	Sidney Moreton	/				reenwood	Maiden Sum	ame <i>)</i>		
ary	and Memari	۲	19a. Informant's Name/Relationship (and Number or Ri					
∑ ~	and 2 leelth m 27 i		David M. Long/ H	usband 			Court, Ga					,
100	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f show among injury, or other treumatic event, the Medical Examinet must be notified at once.	1	20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □		20b. Place of Dispo cometery, crea Germantov	natory or other pla on Baptis	June		20c. Location			
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1	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	he death. Do not ent mer's Dise consequence of):		ng, such as cardia	c or respiratory arr	est,		Approximate Interval Betwo Onset and De	reen
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P.O. Box 6	The law requires that the death centificate ele hes been signed by the ettending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 OoNo 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	y			ate of deliverships the second	_	ear .
ر. ص	signed b	by Pr	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	pacco use co	nIribute to t	he cause of de	ath?
ord	w require been signation	ted						1 🗆 Y	es 2 ⊠No	3 Prot	oably 4 Un	ıknown
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0	ng Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. Injui Wor		28d. Describe ho			<i>y</i> /	
sio	tendir eath. tor: Af the fur	catic	1 XX Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n		M 1 🗆	Yes 2 □No					
Ο̈́	To the Hospital or Attending Physician: The lav within 24 hours elfer death. To the Funerel Director: Affer this certificete hes completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	building, etc.				28f. Location (Si City or Town	n, State)			ar,
	To the Hospital within 24 hours extra the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1. Certifying Pl 2 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1 Medical Example 1	nysician: To the best of miner: On the basis of e and manner state	xamination and/or inv	occurred at the tire restigation, in my o	me, date and place prinion, death occu	, and due to the c irred at the time, d	ause(s) and nate and place	nanner as s , and due to	tated. the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certifier	^		29c. Licens	e number	2	9d. Date sign	ed (Month,	Day, Year)	
	5		1 Srelip ! au	Schreit .	MD	D24	398		June 2	2, 200	16	
			30. Name and address of person who Philip Jay Schwar	completed cause of dea			Rd., #30	2, Rockvi	ille, N	۵D 208	350	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	re constant						

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5, MISTER June 2006 8:20 P M IVA LORRAINE /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Somerset Crisfield 26361 East Pear Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Yrs. 67 Director 215-38-0681 1938 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Crisfield Somerset 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 26361 E. Pear St. 21817 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mote1 Housekeeping 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event QDCS. Be Iva Lorraine Worth Lloyd William White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 25 - Crisfield, MD 21817 Tammy Abbott (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 6/8/06 Paul's Cemetery Marion Station, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Robert H. Bradshaw Jr.

306 W. Main St.- Crisfield, M. Main St.- Crisfield, M. Shock, or heart failure. List only one cause on each line. 306 W. Main St.- Crisfield, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCER **Physician** LUNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exan iner Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 □ No 3 □ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ▼No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 48098 June 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 201 Hall Highway - Crisfield, MD 21817 Vijay Karumbunathan, 31. Date filed (Month, Day, Year) M.D.

DHMH 17 Rev 1/2001

State

Registrar

JUN 0 7 7006

	1	For State Registrar	State of	Maryland		rtmen <i>tificat</i>		ealth and N Death		giene, Rag. No.	2005	19302
		Decedent's Name (First, Middle, Last)							2. Date of De		Vaar	3. Time of Death
Physici	an	Marv Alice	Munzer						June	Day 5	2006	7:30 A ^M
/Medio		Mary Alice 4a. Facility Name (If not institution, give st				4b. City,	Town, or	Location of Death		4c. C	county of Deat	th
Examir	ner						ockv			M	ontgome	erv
		Shady Grove Advent 5. Social Security Number 6. Sex		7. Age (In yrs. I	ast birthday)		1 Year	If Under 24 Hrs.	8. Date of Bir	th	0	thplace (State or Foreign
Funeral		1 🗆	M 2₺ F	79	Yrs.	Months	Days	Hours Min.	Jan. 2	y, Year) , 192	7 Nex	w York
Director		Usual Residence of Decedent							Jan. 2	, 1)2	, 1101	
and w	i i	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
lanyl should	5	Mantagna Mantagna	277		Rocky	7 11 10						1 Yes 2 □ No
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er de	L L	11. Marital Status	Armed For	ces?	3.	f Yes, spe	cify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, Whit	te, etc.
s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	9		1 🗆 Yes	2⊠ No	Specity:		;	Specify: V	Mhite
ural		15. Decedent's Educ		1103.	16a. Dece	dent's Usi	al Occupa	ation		16b. Kin	d of Business	/Industry
a filed within 72 hours after il Hygiene. other then "natural", or Ita vent, the Mad cal Executor	Completed	(Specify only highest grade	completed)		(Give	kind of w	ork done d	during most of world	king	100		
ithic new years	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)			make				Own H	ome
led v lygie har t		17. Father's Name (First, Middle, Last)				ПОШС	marco	18. Mother's Nam	ne (First, Middle	, Maiden S	Sumame)	
be fi tal H d ot	Be						1		Scarry			
Men Men arke	ဥ	William McGrane			405 14-95		- (Canada	and Number or Ru		nor City or	Town State	Zin Code)
s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic avant, the Medical Exprinter must be notified at	1 1	19a. Informant's Name/Relationship (Ty)				_		k Drive				nd 21770
and ealth n 27		Barbara France / 1	Jaught		lace of Dispo		CONTRACTOR OF THE PARTY OF THE	K DIIVE	Date		ation - City or	
of He		20a. Method of Disposition 1 ☐ Burial 2 分 Cremation 3 ☐ R	emoval from	1 0	emetery, crei	matory or	other plac	e) June	_		•	
Pag nent nnt: I		4 □ Donation 5 □ Other (Specify)	_		edericl	k Cre	mato:	ry June 20				Maryland
permit. Pages 'Department of Himportant: If ite any injury or of once.	1	21. Sign ture of Funcial Service Licens	θ /					ss of Facility St				
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Physician /Medical		disease or condition resulting in death)	Due to	or as a conseq	uence of):	alore	7					1
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pet nsit	든	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Re	spirator	u Fai	lure	٠					/ week
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hat the d by	P.	Part II, Other significant conditions con	ntributing to d	eath but not res	sulting in the u	underlying	cause giv	ren in Part I.	23e. Dio	l tobacco u	se contribute	to the cause of death?
ires that signed to d be det	by								1 🗆	Yes 2	□No 3□F	robably 4 Unknown
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e law has b	pje								24a. Wa	opsy formed?		autopsy findings available completion of cause of
Theese pag	5								1□ Yes		1 ☐ Ye	s 2 No
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g Ph terth		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mor	of Injury th, Day Year)	28b. Time of Injury	of	28c. Injui Wo	ry at rk?	28d. Describe	a how injur	y occurred	
Attanding r death.	atic	2 ☐ Accident investigation				М	1]Yes 2 □No				
Atte	2	3 Suicide 6 Could not be determined	28e. Place	e of Injury - At h ling, etc. (Spec	nome, farm, s	treet, facto	ory, office			(Street an own, State		Rural Route Number.
s afte	Certification:		June	g (-p-30.	• •							
Hospital		29a. Certifier (Check only 2 Medical Exam	sician: To th	e best of my kn	owledge, dea	th occurre	d at the ti	me, date and place	e, and due to th	e cause(s)	and manner	as stated.
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exam	and mar	ner stated.	ation and/or i	rivestigatii	ori, iri my (opinion, death occ	unou at the till			
To the within 2 To the comple	Æ	29b. Signature and title of certifier				2		se number				nth, Day, Year)
P S P O		DA NINA	LAAA	1.			Do	063120	1	JU	NE 5,	2006
10		30. Name and address of person who d	ompleted car	se of death (Ite	m 23a) (Type	Print)						
S		Parlimi NA	NYAD				1 Ce	nter Driv	re Roo	kvil.	le, Mar	yland 20850
		31. Date filed (Month, Day, Year) 2	32.			1 -	,				-	
Regis	state strar	JUN 0 7 2	306	egistrar's Sign	D A	THE REAL PROPERTY.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 12 per fh 8856 6-19-06 vt. State of Maryland 7 Department of Health and Mental Hygiene 0 0 6

19303

			Registrar				Cel	uncate of	Deaiii		Reg. No.		
	ysicia Medic		1. Decedent's Name		st)		ΜI	LGRAM		2. Date of E Month MAY 3	eath Day 2006	Year	3. Time of Death 2:59 P M
	amin	_	4a. Facility Name (If HOLY CRO	not institution, giv		r)		4b. City, Town, SILVER	or Location of De SPRING	eath		unty of Deat	
	eral ector		5. Social Security No. 083-28-88	363	Sex 1□ M 2□ F		ast birthday) 75 Yrs.	If Under 1 Year Months Days		lin. (Month, L	lirth Day, Year) 27, 193	Co	hplace (State or Foreign untry) W York
and	201		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	calion					10d. Inside City Limits
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the 1	rott	rec	10e. Street and Nun	nber				10f. Zip Code			10g. Citizer	of What Co	untry?
h with	2	0	11213 Mor	nticello	Avenue			209	0.2			S. A.	•
deat	Ē	Funeral Director	11. Marital Status		12. Was Deceder	nt Ever in U	S. 13. \			(Specify Yes or Nerto Rican, etc.)		Race - Ame Black, White	
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. 27 is marked other than "natural", or Iteme 23a or 28a-f ehow	ă	2	1 Never Marrie		1 1 Yes 2 If Yes, Give Year or Dates	□No Ar	my .	1□Yes 2√√ No					White
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Hygie A	Tu .	ပိ	17. Father's Name (First, Middle, Last)	5 +		Mat	пешастст	T	Name (First, Midd			1 Science
aryland should be and Mental	ic ev	o Be	Murray	Milgram	1				Ce.	lia Lauf	er		
Shou shou	umat		19a. Informant's Na	me/Relationship (Type, Print)		19b. Mailin	g Address (Street	t and Number or	Rural Route Num	ber, City or To	own, State, Z	Zip Code) 20902
and 2 melth 3	at t		Edith M	lilgram –	· Wife		11213	Montice	11o Avei	nue, Sil	ver Spr	ing,	Maryland
or He	£0	. 1	20a. Method of Disp		Removal from Stat	0.00	lace of Dispo emetery, cren	sition (Name of natory or other pla	ice)	Date	20c. Locat	ion - City or	Town, Slate
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Baltimore, Marylan permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked.	ny in		21. Signature of Fu	neral Service Licer	nsee		$E_{\mathbf{d}}^{22}$	Name and Address Ward Sag	ess of Facility eI Fune:	ral Dire	ction,	Inc.	
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O , en an	rial-tr		resulting in death) L	ast	Due to (or a	is a consequ	ience of):						
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rds quires n sign	Pd ba	d by	CORONA	RY ARTER	Y DISEASE					_ 10	Yes 2□N	o 3 Pro	obably 4 🖾 Unknown
Records, he law requires to the been signed.	should	Completed	PERIPH	ERAL VAS	CULAR DIS	EASE				24a. Wa	s an 2	4b. Were au	topsy findings available ompletion of cause of
The 1st te he	999 2	mo								per	formed?	death?	ompletion of cause of
	ō	BeC	25. Was case referr examiner?	ed to medical					26. Place of D	Death Check only	2⊠ No one)	1 103	2 140
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IVISION r Attending ter death. Irector: After	the f	cati	2 ☐ Accident 3 ☐ Suicide	investigation					Yes 2 No				
DIVI I or All efter of Direct	in by	Certification:	4 Homicide	determined	289. Place of I	njury - At ho etc. <i>(Specify</i>	me, larm, stre	eet, lactory, office		281. Location City or To	(Street and No own, State)	umber or Rui	ral Route Number,
To the Hospital within 24 hours e	completely filled		29a, Certifier	1⊠ Certifying Ph	nysician: To the bes	et of my know	wledge death	occurred at the tr	me, date and pla	and due to the	2 22 42 2 (2) 2 2 2	1	
Hos 124 h	letely	Medical	(Check only one)	2 Medical Exam	miner: On the basis and manner:	of examinat	ion and/or inv	estigation, in my	opinion, death oc	courred at the time	, date and pla	ce, and due	to the cause(s)
To th To th	сошр	M	29b. Signature and	title of certifier	0	0		29c. Licens	se number		29d. Date si	gned (Month	, Day, Year)
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			ALAN R.			HUGO C			SPRING,	MD 2090	6		
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State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** June 9,2006 McDaniel 4:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakland Nursing and Rehab Center Oakland If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Pay, Year 9/14/1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 X M 2 ☐ F 90 Director 236-03-7250 Whitmer, WV Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exertetion must be notified at 1 Yes 2 No Director WV Preston Aurora 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Rt. 1 Box 348-A 26705 USA Completed by Funeral illed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 X No Yes. Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Laborer Lumber Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. Be William McDaniel Isabelle Click 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Snyder/ Daughter Rt. 1 Box 348-A, Aurora, WV 26705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Omega Crematory 6/12/06 Morgantown, WV 22. Name and Address of Facility 21. Signature of Funeral Service 32 S. Second St. Stewart Funeral Home Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Respiratory Failure 1 Week /Medical Due to (or as a consequence of) Examiner Emphysema Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Asbestosis Years attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached t 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Dementia, Chronic Anemia, Chronic Renal Failure 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√√ No 24a. Was an page 2 certificate 1 Yes 2 XN0 or Attending Physician: After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ٥ 1 ☐ Yes X∏ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 6/9/06 Han 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret A. Kaiser MD 13079 Garrett Highway, Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 12 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 11:00 AM **Physician** 06 Evelyn Muir 0 α /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lonaconing 17707 Lower Georges Creek Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 201F Months Days Hours Min Maryland Yrs. November 11, 1923 216-18-1976 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
and if Health and Mental Hygiene.
and if Health and Z I emarked other then "natural", or flema 23s or 28s-1 ehow and it is health Earth in must be notified at any or other traumatic event, if a health Earth in a must be notified at 1 Yes 2 No Lonaconing Director Allegany Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 17707 Lower Geroges Creek Road 21539 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 2) No Baltimore, Maryland 21215-0036 Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Donald Harry Lease ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17707 Lower Georges Creek Road, Lonaconing, Maryland, 21539 Judy Thomas - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 07, permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Moscow Mills, Maryland Laurel Hill Cemetery 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A., 8 East Main Street, Lonaconing, Maryland, 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on learn failure. List only one cause on each line.

Immediate Cause (Final disease condition) Approximate Interval Between Onset and Death ten a 91144 WIPES **Physician** disease or condition resulting in death) /Medical Examiner di sease end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1-a ft pass 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has al director, page 2: 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 2 No Other: 4 Nursing Home Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Maryler of Death After 1 Natural 5 Pending investigation 1 □ Yes 2 □ No М n 24 hours after death.

Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hazen Loan 40 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 400 Month Year **Physician** PM PETER MIRIGO JUNG MUICHMI 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LAUGER REGIONAL PMNCE GBORGE LAUREZ HUSPITM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 Q M 2 □ F Hours Director 56 None July 6, 1949_ Tanzania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits in then "naturel", or items 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11616 Tuscany Drive death 20708 by Funeral Tanzania Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours after entment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or ite injury or other traumatic event, the Medical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Legal Consultant Management, Engineering (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Project Planning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Mukami Joseph Maria Nchagwa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 11616 Tuscany Drive
20b. Place of Disposition (Name of cemetery, crematory or other place) Norah Petro Mukami Wife Laurel, Maryland 20708 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tarime Cemetery Jun. 7, 2006 Mara, Tanzania 21. Signature of Funeral Service Licensee 22. Name and Address of F Francis J. Collins Funeral Home, Inc. Ken Skiles 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAIWRE **Physician** ACUTE RESPIPATURY disease or condition resulting in death) 48 HOURS /Medical Due to (or as a consequence of) Examiner BARTERIAL PNEUWOWIA 2 wishes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed 6 NWW TUS RENAL CELL CARGINAMA METASTATIC Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown LUZIGNANT PLOUDER ERVISION Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ANTARCA autopsy performed? MAUNITRITUM 1 Yes 2 XNO 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident efter death Director: / I in by the f 3 TSuicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D36474 JUNG 1 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE PATUXENT DAILIEWAY CULU MIBIA 21544 OIM MUTEURAYM. O CHURCH CINT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 5 2006 Registrar

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י	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23e or 28e-f show other traumatic svant, the Medical Exactions from the notified at		DEBRA A. STUBBLEFTE	D/DAUGHIEK	20b. Place of Disp cemetery, cre	TAMARACK R		C SPRING, I		.0904 City or Town, State
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DIVISION	or Ati	Certification;	3 Suicide 6 Could r 4 Homicide determ		ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rural Route Number,
4	spital ours a neral I		29a. Certifier 1 Certifyin	g Physician: To the best of	of my knowledge, dea	th occurred at the t	me, date and place	, and due to the	cause(s) and mar	nner as slated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending frompletely filled in by the funeral director, page 2 should be detached for use as	edical		Examiner: On the basis of and manner sta	examination and/or in					
	To # To # comp	29b. Signature and title of certified 29c. License number 5000235							_	(Month, Day, Year)
)	15		200	0,00	M. FACC		00235			315 2006.
			30. Name and address of person 7350	who completed cause of de	Path (Item 23a) (Type	, Print) FEROZ I	PADDER, M.D.	K, MD	20707.	

Registrar

State

31. Date filed (Month, Day, Year)
JUN 5

2006 Seguritar's Signature

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	Dhamist			ecedent's Name										2. Date of De Month	ath Day		Year	3. Time of Death
	Physicia /Medic			Kimberly 		Nicol		Neely		T				May	21		006	12:53P M
	Examin	er		Facility Name (If r						4b. City,		Location of	of Death			County o		
				Doctors'		inity 6. Sex		oital 7. Age <i>(In yr</i> s.	last birthday	If Under	La 1 Year	nham If Under	24 Hrs.	8. Date of Bir	th	lnce		ace (State or Foreign
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f ehow emportant: if item 27 is marked other then "natural", or items 23a or 28a-f ehow entry injury or longer than the page.	Completed by Funeral Director		Marital Status Never Married Widowed 4			Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	edent Ever in Urces? 20 No 76 ates:		Was Deced If Yes, spec 1 \(\text{Yes} \)		ispanic Ori n, Mexicar Specify:		city Yes or No Rican, etc.))-	14. Race Black Specify:	- Americ , White, (an Indian, etc. Black
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Baltimore, Maryland 21215-0036	Mental H Mental H mrked ot atic ever	To Be	17.		th Ne								Clea	ster Ta	ate			-
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			23	a. Part . Enter the shock, or hear	disease, or	complicati	ions that o	aused the dea	ith. Do not en	ter the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
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	xecut and II-tran	хап	tha	use (Disease or in at initiated events sulting in death) La	ist	С.	_	or as a conse		rallu	16						-	Days
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687	ificate g phy as the	B				70.												
P.O. Box	that the death certifica hed by the attending ph detached for use as t	Physician/M		FEMALE: b. Was decedent j in the past 12 g 1 Yes 2 9 Unknown	onths?	i.	1 Live b	come of pregr pirth 2 Fet nant at time of own	al death 3	⊒Ectopic pi ⊒ Other (sp					2	23d. Date Mont		ory Day Year
	res that igned by be deta	by Ph	Par	rt II. Other signific	ant condition	ns contrib	uting to d	eath but not re	sulting in the u	underlying o	ause give	en in Part I		23e. Did 1	obacco u	se contrib	oute to th	ne cause of death?
rds	w requires been sign should be		_	Pulmo	nary	Hyper	tens	ion						10	Yes 2]	QNo 3	Prob	ably 4 \(\begin{array}{c}\) Unknown
of Vital Records,	2 S T S	Completed												24a. Was		24b. W	ere autor	psy findings available inpletion of cause of
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/ita	iclan: T certificate rector, pa	Be (25.	Was case referre	d to medical								of Death	(Check only	one)			
£	S S D	၉	-	1 ☐ Yes 2 € N	lo	Hosp	ווי		ER/Outpatie			4 🗆 140		ne 5 Resi				1)
n C	ing F	lon	27.	Manner of Death 1 ☑Natural	5 Pendin	9	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	M	28c. Injun Work	yat k? Yes 2. □		28d. Describe	now injur	y occurre	a	
Division	Attending r death. ector: After by the fune	flcat		2 Accident 3 Suicide	investig 6 Could determ	not be	28e. Place	of Injury - At I	home, farm, st								or Rura	I Route Number,
Ö	after after Dire	Certification:		4 Homicide	determ	illed	build	ing, etc. (Spec	eify)	,	,			City or To	wn, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29	a. Certifier (Check only 2	Certifyin	g Physici Examiner	: On the b	best of my kr asis of examir ner stated.	nowledge, dea nation and/or i	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ad at the time,	cause(s) date and	and man place, ar	ner as st nd due to	ated. the cause(s)
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	->-0			Dow	enk	2/6	30	o do u	120 m	OD	0043	180			May	23,	2006	,
_	6		30	. Name and addre	ss of person	who comp	leted cau:	se of death (Ite	om 23a) (Type	, Print)								
				Karen L			· · · · · · · · · · · · · · · · · · ·		Execut		lace!	#50	01,	Lanham	, MD	2070)6	
170	Sta Regist		31	. Date filed (Month	, Day, Year)	2006		Registrar's Sign	nature	wi								

		-	For State Registrar	State of	f Marylaı	nd / Depa	artment rtificate	of Hea	alth and eath	l Mental Hy	giene 2 Reg. No.	006	1.930	9
	Physicia	20	1. Decedent's Name (First, Middle,			D t				2. Date of De. Month	ath Day	Year	3. Time of Death	
	/Medic	al	Carolan	Sue		Porter				06	14	06	05155 M	_
1	Examin	er	4a. Facility Name (If not institution,						cation of De	ath		legar		
			WMHS- Braddo 5. Social Security Number		MPUS	. last birthday)	If Under 1		Under 24 H	rs. 8. Date of Bir	h	9. Birth	place (State or Foreign	
	Funeral Director		215-56-8872	1□M 2□ X	55	Yrs.	Months	Days H	lours M	rs. 8. Date of Bir in. Wonth, Da Mar 1	0,°°195	1 Co	MD	
			Usual Residence of Decedent		1.0									_
	arylar show	_	10a. State 10b. County Mine	ral	10c. C	ity, Town or Lo Ridg	eley						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he M	ecto	10e, Street and Number				10f. Zip (Codo			10a Citizar	n of What Co		_
	with ta or 1	Funeral Director	P.O. Box 672				TOI. ZIP		6753		rog. Ottzer	USA	arity :	
	death	era	11. Marital Status	12. Was Dece		J.S. 13.	Was Decede	nt of Hispa	ınic Origin?	(Specify Yes or No	- 14.	Race - Ame		_
9	after or ite	F.	1 Never Married 2 Marrie	Armed Fo i 1 ☐ Yes If Yes, Giv	2 🗆 XVo		ir Yes, specii 1 ☐ Yes 2	X	oexican, Pu Specify:	erto Rican, etc.)	S	Black, White		
ဗ္ဗ	urel',	d by	3 Widowed 4 Divorced	Year or Da	ates:							pecify: Wh		
<u>7</u>	"nat	lete	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupation done durir retired)	n ng most of v	vorking	16b. Kind	of Business/I	ndustry	
7	withii iene. then	dmo	Elementary/Secondary (0-12)	College (1	-4or 5+)		epartm				Marti	n's Foo	od Store	
and	I be filed ntal Hyg ed other: event,	Be Completed	17. Father's Name (First, Middle, La Raymond We	sley Wills	S			18		lame (First, Middle, E. Cottril				
Mary	d 2 shouk th and Me t7 is mark treumatic	7	19a. Johnmant's Name/Relationship	o (Type, Print) d	aughte	r ^{19b} Rol	ng Address	Street and	Number or	Rural Route Number	er, City or To	own, State	7 26753	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelip and Mental Hygiene. Important: If Item 27 is marked other then "naturel" or items 23s or 28s-f show important: If Item 27 is marked other then "naturel" or items 23s or 28s-f show eny injury or other treumstic event, I'm Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			Place of Dispo competers of P Carpelli F			P.Å.	Date 6/16/200		tion - City or Saptow		
Baltir	permit. P Departmo Importar eny injur		21. Signature of Funeral Service Li	· · · · · · · · · · · · · · · · · · ·	nind) - 2:				Home, PA	rland, I	MD 2150)2	
	Coate be executed /Medical Examiner sthe burial-transit	ıl Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ach line.	quence of):		of dying, s		ac or respiratory a	rest,		Approximate Interval Between Onset and Death WWWW	7
.O. Box 6	the death certify the attending ched for use a	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		inth 2 ∏ Fel antattime of	tal death 3	□Ectopic pre □ Other (spe				230	I. Date of deli Month	very Day Year	
ds, P	8 6 6	<u>م</u>	Part II. Other significant condition	s contributing to de	eath but not re	sulting in the u	nderlying ca	use given îi	n Part I.		obacco use ∕es 2□N		the cause of death?	
Division of Vital Records,	e iaw has t	Completed								24a. Was autop perio		prior to death?	topsy findings available completion of cause of	
ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26	6. Place of D	eath (Check only o	ne)			
7	Physicien: this certific ral director,	၉	1 ☐ Yes 25€No	-		ER/Outpatie				Home 5 Resi			cify)	
n C	After Line	<u>6</u>	27. Manner of Death Natural 5 Pending		th, Day Year)	28b. Tîme d Injury	M 28	lc. Injury at Work?	2 □ No	28d. Describe	10w injury o	ccurred		
Division	or Attending after death. Director: After	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At ng, etc. (Spec	home, farm, st			2 🖺 140	28f. Location (City or To		lumber or Ru	ral Route Number,	
_	Hospita 4 hours Funeral	edical Ce	29a. Certifier (Check only one) Certifying 2 Medical E	caminer: On the b	best of my kr asis of examir nex stated.	nowledge, deat nation and/or in	h occurred a vestigation,	t the time, in my opini	date and pla on, death or	ace, and due to the courred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11 000	μ		29c.	License nu	umber		29d. Date s	igned (Monti	n, Day, Year)	_
	, , , , , , 0	1	> April					1061	747	8	06	0-14-	06	
	2		30. Name and address of rerson w	ho completed caus	se of death (Ite	em 23a) (Type	Print)	^^	P		10.	11)	21.60=	
			UR H HHMAD 31. Date filed (Month, Day, Year)	625 KI	ENT H	VE SU	ITE 10	02	W	MBLELAN	0 11	11)	21502	-
Ą	Sta Regist		JUN 1 9 20		w D	Ripe								

			Stare Registra AVEND#31sec#32,6/2/9	te of Maryland / Department / D	artment of H		Reg	g. No.	19310
			1. Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death
	Physicia /Medic		Sarah Alice Posey				May	27, 2006	2:30 a M
)	Examin		4a. Facility Name (If not institution, give street a	nd number)		r Location of Death		4c. County of Death	
			Shady Grove Nursing		Rockvi.		0.000.000.00	Montgome	
г	Funeral		5. Social Security Number 6. Sex 1 M 20	7. Age (In yrs. last birthday) 99 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 April 20	Year) 9. Birth Cou	place (State or Foreign intry) rginia
١.	Director		Usual Residence of Decedent	99			APITI ZO	,1907 VI.	Iginia
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man I eh	tor	Maryland Montgomery	Rockvil1	Le				1 ☐ Yes 2 🖾 No
	r 28g	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
	th wit		9701 Medical Center	Drive	20850			United Sta	ates
	deal	Funeral		s Decedent Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9	or It	/Fu	If Y]Yes 2 🔼 No es, Give	1 ☐ Yes 2 ☒ No	Specify:		Specify:	• .
8	within 72 hours after death with the Maryland ene. then "returel", or items 23a or 28a-f ehow he Mavical Examiter must be notified at	d by		ar or Dates:	d#- 1/ O		1.4		ite
<u>γ</u>	"net	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing "	6b. Kind of Business/lo	idustry
12	withir ane. then	E D	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	ısewife	,		Own Home	
2	e filed within al Hygiene. I other then '	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	laiden Sumame)	
an	d be ental ked o	To B	Unknown Morgal			Agnes	Unknown		
Maryland 21215-0036	2 should be and Mental ie marked reumetic ev	-	19a. Informant's Name/Relationship (Type, Pric	nt) 19b. Maili	ing Address (Street		al Route Number,	City or Town, State, Z	ip Code) 20874
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 ie marked other then "neturet", or items 23a or 28a-f ehow other treumetic event. The Maryleal Examither mat be mailified at	1	Mary Hamby / Daughte	r 18715	Sparkli	ng Water	Drive #10	01; German	town, MD
Je,	of Health item 27		20a. Method of Disposition	20b. Place of Disposemetery, cre	osition (Name of matory or other place	(60	Date 2	0c. Location - City or T	own, State
Ë	Page Int: #		1 ☐ Burial 2 【XCremation 3 ☐ Remova `4 ☐ Donation 5 ☐ Other (Specify)	Ft. Linco		1	/2006	Brentwood	d, Maryland
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	1 S ²	2. Name and Addre	ss of Facility	ral and (Cremation (Center
B	88 = 8		ten tim fisch-	(vely) 10)40 Rockv:	<u>ille Pike</u>	; Rockvi	lle, Maryla	and 20852
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death. Do not en se on each line.	iter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Old age					Onset and Death 5
	/Medical		resulting in death)	Due to (or as a consequence of):					100
В	Examiner	l.	Sequentially list conditions, b.	Osteoporosis					20
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	oue to (or as a consequence of):					
_	be executed ician and burial-transit	Examiner	that initiated events c	Due to (or as a consequence of):					
760,	be executed sician and burial-transit	calE							
687	9 % 9		d						
Box (eath certific attending pl	Ž		es, outcome of pregnancy				23d. Date of deliv	very
m	death certifica e attending ph of for use as th	icia	in the past 12 months?	Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i> _	y 		Month	Day Year
0	at the de by the a	Physician/Med	9 □ Unknown 9L] Unknown					
S, D	The law requires that the tte has been signed by threage 2 should be detache	by P	Part II. Other significant conditions contribution		underlying cause giv	en in Part I.	_	acco use contribute to	
Records,	w require been si should b		History of congestive	e heart failure			1 Tes	s 2XINO 3 Pro	bably 4 □Unknown
ecc	e law re has be je 2 sh	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
E E		Con					perform 1 Yes 2		2 No
Vital	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	6.	Oth		th (Check only one	*	
of	S 0 =	2	1 Yes 2LXNo	. Date of Injury 2 Bb. Time of	AIR SELDON		ome 5 Resider 28d. Describe hov	nce 6 Other (Spec	ify)
		lo	1 XNatural 5 Pending	(Month, Day Year) Injury	Wor	rk? Yes 2□No	200. 2000.100 110.	,,	
Division	ten deat tor: the	fica	3 Suicide 6 Could not be 286	. Place of Injury - At home, farm, s	treet, factory, office			eet and Number or Ru	ral Route Number,
Div	after after Direct	Certification:	4 Homicide	building, etc. (Specify)			City or Town,	, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune		29a. Certifier 12 Certifying Physicien:	To the best of my knowledge, dean the basis of examination and/or in	th occurred at the ti	me, date and place,	and due to the car	use(s) and manner as	stated.
	he Ho in 24 he Fu pletel	Medical	one) at	nd manner stated.					
	with To t	Σ	29b. Signature and title of certifier	1	29c. Licens	se number 9 6 9		d. Date signed (Month	
•	3		1-0000	cuy us				May 30,	2006
			30. Name and address of person who complete	ed cause of death (Item 23a) (Type	e, Print)	America		2 4 11	Mar and Gar
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	edical can	les IV.	9320	KUCKUITE.	(10 20850
	St Regist	ate rar	The troining bay, 16ary	JUN 2 2006	Breue	H. Age	de la		170 20850
			1 101 1 2 2 2 2 2		A STATE OF THE PARTY OF THE PAR				

State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 3, 2006 **Physician** William John 11:15AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Howard 9048 Furrow Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 1, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Massachusetts 017-05-9704 86 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturs!, or itsms 23a or 28e-f show tra Medical Examinar must be notified at 1 Yes 2 No Ellicott City Maryland Howard Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9048 Furrow Avenue 21042 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Obstetrician Healthcare marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Celia McGee Augustus Adolphus Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21042 9048 Furrow Avenue Alison Roy-Harrison/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 06/06/06 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Fund of Service cirens Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 0 23a. Part 1. Enter the Tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician melanona Tmentos resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death
4☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 4 Dunknown 1 Yes 2 No 3 Probably peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ 16 24a. Was an has page 2 autopsy performed certificate 1□ Yes 2□ No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medicai Certification: 27. Manner of Death 28c. Injury at Work? After VI Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A M investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific DUS7936 06-05-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HECHNOLD MONNULL WO 900 COLON AVE. BUILDING, MD 2127P teather a Mannuel 31. Date filed (Month, Day, Year) 32. Radistrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Physician **JORGE** RUBIO 1740 2006 LINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULL CISHAL MADICOL Niconico Il Under 24 A If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV • 25 , 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**]** M 2 □ F 46 Yrs 216-08-4738 1959 Director Mexico Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke rthan "natural", or items 23a or 28a-f eho the Medical Examinar must be notified at Somerset Crisfield 1 ☐ Yes 2 ☐ No Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Mith 26644 Old State Road 21817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No Specify: Mexican Baltimore, Maryland 21215-0036 Hispanic Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farm Laborer Orchard Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: if item 27 is marked othsr th jury or other traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Juan Rubio Ramos Amparo Franco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26644 Old State Road - Crisfield, MD Mary Louise Rubio (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Department of important: if any injury or once. 4 Donation 5 Other (Specify) Zinapecuaro, Mexico Zinapecuaro, Mexico 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruitt

23a. Parl. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home

306 W. Main St. - Crisfield, 306 W. Main St. - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBELLAR Physician HEMORRITAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the e d be detached for o 9□ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Division of Vital Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and tule of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19432 30. Name a son who completed cause of death (Item 23a) (Type, Print) addre SUUUS ZANT 100 E. CAINI ST. SAUSBUM 32. Register's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thomas Junior Richardson M JUNE 2006 0923 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⋈**M 2□ F 220-16-6292 82 Director December 07, 1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23e or 28e-f show ury or other traumatic event, the Medical Examinar matt be notified at ury or other traumatic event, the Medical Examinar matt be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Allegany Directo Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17109 Lower Geroges Creek Road 21539 U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or 5+) Teacher School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Oscar Richardson ္က Ruth Mae Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Thomas Richardson - Son 17109 Lower Georges Creek Road, Lonaconing, Maryland, 21539 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 08, 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If sny Injury or once. Laurel Hill Cemetery 4 □ Donation 5 □ Other (Specify) 2006 Moscow Mills, Maryland 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A., 8 East Main Street, 21. Signature of Funeral Service Licensee E. Mile Lonaconing, Maryland, 21539 23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION, CONGESTIVE HEART FAILURE 2 ☐No 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2⊡No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital ဥ 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54411 JUNE 5 2006 of person who completed cause of death (Item 23a) (Type, Print) 6+VA DR. BEVERLY CALKINS 500 MEMORIAL AVENUE SUITE 105 CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2001 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005

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Maryland	sho man	ľ	19a. Informant's Name/Relati	onship (Type, Print)		19b. Mail	ng Address (S	treet and Num	ber or Rur	al Route Numb	er, City	or Town,	State, Zip	Code)	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.						2	Name and A	ddress of Eac		2006	Rock	CVil	le, Ma	arylai	nd
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Amended #9, n1s, 06/07/06, Allegany Co.

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State of Maryland / Department of Health and Mental Hygiene 0 0 6

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Director		466-10-9027	ØM 2□F 87	Yrs	Month:	Days	Hours Min.	FEB 24		1LLIN	ntry)
pur N		Usual Residence of Decedent 10a, State 10b, County	100.0	city, Town o	r Location				·		
Aarylan I ehow	or									'	10d. Inside City Limits 1 ☐ Yes 2 2 No
tha M 28a-f	Director	VIRGINIA ACCOMA	CK 17	TLAI		ip Code			10g. Citizen o	f What Cour	
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I and 2 should be filed within 72 hours after death with the Maryland Health and Mantel Hygians. Health and Mantel Hygians are filem 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, ire Medical Examinar must be notified.	by Fui	1 ☐ Never Married 2月 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No No No No No No No No No N		if Yes, sp 1 ☐ Yes		Specify:	to Hican, etc.)	Spec	lack, White,	etc.
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s 1 and 2 f Haalth item 27 other tra		MARGARET F. STE, 20a. Method of Disposition		Place of Di	sposition (N	ame of	IC KONL	Date ATL	20c. Location	n - City or To	23305 wm. State
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Parmi Dapa Impo eny ir) James 7	1. Fot		FOX FU	VERAL	HOME	TEMPERAN	reville	110 3	23442
Physician /Medical		23a. Part 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the decore cause on each line. a	nen	enter the mo	de of dying	, such as cardiad	or respiratory ai	rest,		Approximate Interval Between Onset and Death
icata ba axecutad ax physician and stransit aburial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. C. ASCU Due to (or as a consect.)	15	all	n e					
		TO FERMINE									
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that	by Pr	Part II. Dther significent conditions of	ontributing to death but not re	sulting in the	e underlying	cause giver	n in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
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hysic his ce	2	1 □ Yes 2 □ No		☐ ER/Outpa	tient 3 🗆 🗅	OA Other	4 Nursing H	ome 5 Resid	lence 6 🗆 Ot	ther (Specify)
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tend daath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 No				
after of Direct of in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, ify)	street, facto	ry, office		28f. Location (S City or Tou	itreet and Num m, State)	iber or Rurai	Route Number,
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this cartifics complately filled in by the funeral director, f	Medical C	29a. Certifier Certifying Ph (Check only one)	ysician: To the best of my kn liner: On the basis of examin and manner stated.	owledge, de ation and/or	eath occurre r investigatio	at the time n, in my opin	, date and place nion, death occu	, and due to the orred at the time, or	ause(s) and mate	nanner as sta , and due to	ated. the cause(s)
To the To the Comp	ž	29b. Signature and title of certifier			29	c. License	number		29d. Date sign	ed (Month, L	Day, Year)
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A511			completed cause of death (Ite	m 23a) (Typ	oe, Print)			by Me	1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State #7, per f.home, 6/7/06, E.TCertificate of Death WCHD Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Howard Gene Sams 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death TENINSULA REGIONAL MEDICAL CONTO SAUSBUR NICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days 1**⅓**M 2□ F Hours Yrs Director 577-56-4430 63 63 5/8/1943 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehow other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Funeral Director 1 TYes 2 TXNo MD Worcester Whalevville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? - 23a 11702 Back St. 21872 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∏Yes 2 **∑X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Be Completed by Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Craftsman Jewelry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If flem 27 is marked oth any lighty or other traumatic event SDB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Sams Shirley Dakin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Sams 11702 Back St., Whaleyville, MD 21872 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 6/8/2006 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 10<u>8 William St.,</u> Berlin, MD 21811 23a Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Figal **Physician** Congesque to (or as a consequence of): Nanth resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 625 the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, ourcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Yes 2 No 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an aulopsy performe 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpafient Medical Certification; To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature appr title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Ite. 23a) (Type, P int) 106 hr close or la

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar 2006 32. H

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month Physician BENNETT WAYNE STERLING 2006 6:55 P. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crisfield Somerset Alice Byrd Tawes Nursing Home If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 88 Yrs Director 220-26-3339 1918 Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event. The Modical Exportment for notified at Crisfield Somerset Maryland 1 X Yes 2 No Director (he 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 2 any injury or other fraumatic event, the Madical Export mericant by ance. U.S.A. 21817 1 Village Drive - Apt. 9 Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1- Yes 2 No World 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: 3 Widowed 4 Divorced Year or Dates: War II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mabel Ellen Landon Bennett Tutson Sterling ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3815 Gandy Lane - Crisfield, MD Shirley Jones (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Sunnyridge Mem. Park 6/8/06 Crisfield, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature Robert H. Bradshaw. Jr. 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -CZHeimer 5 STAGE **Physician** eARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-trar Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) o detached 9 Unknown The law requires that the 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 certificate has autopsy performed Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mist Mughung, Mistrald, un 20017 31. Date filed (Month, Day, State eve & Sparke Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY Day 20°06 **Physician** THOMAS EDWARD STONE 31 12:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 25, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** t**√**M 2□ F 579-42-9194 85 1920 Wash. Director Usuaf Residence of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No MD Frederick Frederick Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 4820 Hargett Lane 21702 USA 238 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No W • If Yes, Give Year or Dates: III items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Madical Examinat W. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) medicine physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Stone Bessie Coblentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Alan Stone (Son) 5001 Blythewood Rd., Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6/3986 1 ☐ Burjel 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Smithsburg Crematory 21. Signature of Funeral Service Lices Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 e. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only ne cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, fmmediate Cause (Final disease or condition resulting in death) Physician wh DIROCTI /Medical Due to (ar as consequence of): Examiner trinum's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Completed by 1 Yes 22 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home hours after death. Ineral Director: After this ce y tilled in by the tuneral dire 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral L * Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 009689 06 -0 UVVZ 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) St Frederick Ald 300 Niwth 31. Date filed (Month, Day, Year) JUN 0 gistrar's Signature 7 2006 Registrar

	1	For State Registrar			Cer	tificate of	Death	Mental Hygio	J. No.	00	1932
		1. Decedent's Name (First, Middle, Las.	t)					2. Date of Death Month	Day	Year	3. Time of Death
hysiciar /Medica		Pamela J.	Solomon_					May 28			6:50A
Examine		a. Facility Name (If not institution, give	street and number	or)			or Location of Deat	h	4c. County of	of Death	
		The Casey House				Rockvi			Montg		
inerat		5. Social Security Number 6. Se	ex 7.7 ⊐M 20X0F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,)			ace (State or Fore try)
rector	-	577-04-6821 Usual Residence of Decedent		61	115.			11-26-44	+	Engla	and
* =	-	10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Lim
F 5	5	MD Montgome	rv	Reth	nesda						W∏Yes 2□
289	5	10e. Street and Number	- L y	Deel	reoda	10f. Zip Code		100	g. Citizen of W	hat Count	trv?
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury prother traumatic event, the Medical Examinar must be notified at once. To De Completed by Europeal Diseases	5	7902 Springer Rd.				208	17		U.S.		,.
THE STATE OF THE S	~ L	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. \	Nas Decedent of I	Hispanic Origin? (S	Specify Yes or No-	14. Race	- America	an Indian,
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Target I	<u></u>	3 ☐ Widowed 4 🍒 Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2X No	Specify:		Specify:	Whi	ite
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§()	1	20a. Method of Disposition	D	_ cen	netery, cren	sition (Name of natory or other pla	ce)		oc. Location - 0	City or Tov	wn, State
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	ed the death.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arres	it,		Approximate Interval Between
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detached for use as	Physician/Me	230. was decedent pregnant	23c. If yes, outcom	ne of pregnand 2 Fetel d		Ectopic pregnanc	v		23d. Date		•
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be de	2	Part II. Other significant conditions co	ontributing to death	but not result	ing in the ur	nderlying cause gr	ven in Part I.	23e. Did toba			e cause of death?
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	0	examiner? 1 Yes 2 No	Hospital:	ıtient 2□E	RVOutpatien	t 3 DOA Ot		dome 5 ☐ Residen		(Specify)	Hospice
eral		27. Manner of Death	28a. Date of Ir (Month, I	njury 2	8b. Time of	28c. Inju Wo		28d. Describe how			
e fun	읉	1 Natural 5 Pending 2 Accident investigation		Jay 1 Gar/	Injury		Yes 2 No				
S i	<u>≅</u>	3 Suicide 6 Could not be determined	209. Flace 01	Injury - At hom	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number	r or Aurai	Route Number,
À 3		4 I Nomicide	building,	etc. (Specify)				City of Town,	State)		
d in by	9		ysician: To the be	st of my knowl	edge, death	occurred at the ti	me, date and place	e, and due to the cau	se(s) and man	ner as sta	ited.
y filled in by the funere	a Ce	29a. Certifier 1 Certifying Ph		of examination	n and/or inv	vestination in my	opinion, death occu	irred at the time, dat	e and place ar	nd due to	the cause/s)
Metely filled in by	edical Ce	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Exam	iner: On the basis and manner	stated.		restigation, artify	-		o and place, a		tile Cause(s)
completely filled in by	edical	(Check only 2 Medical Exam	niner: On the basis and manner	stated.		29c. Licens			d. Date signed		
completely filled in by	edical	(Check only 2 Medical Examone)	niner: On the basis and manner	stated.	>		se number			(Month, D	Day, Year)
completely filled in by the funeral discontinuous	edical	(Check only 2 Medical Examone)	and manner	stated.	>	29c. Licens	se number		d. Date signed	(Month, D	Day, Year)

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State of Maryland / Department of He	alth and Mental Hygiene 🔠 🕕	

		For State Registrar 1. Decedent's Name (First, Middle, Last,	State of Maryland		artment of H			leg. No.	Year	3. Time of De
Physicia /Medica Examine	al	Phyllis M. Sisson 4a. Facility Name (If not institution, give Holy Cross Hosp	street and number)		4b. City, Town, or Silver	Location of Death	June 2,	2006 4c. County		
uneral irector		5. Social Security Number 6. Se 219–48–5962	7. Age (In yrs. In 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 23	, Year) 3, 1924	9. Birth Cou Indi	iplace (State or Fo intry) Lana
Ba-f show	ector	10a. State 10b. County Maryland Montgome 10e. Street and Number		, Town or Lo	Spring 10f. Zip Code			10g. Citizen of	What Cou	10d. Inside City L 1 ☐ Yes 2
e 23a or 2 must be n	Funeral Director	8505 Springvale Ro	ad 12. Was Decedent Ever in U.	S 13	20910			U.S.A	١.	ican Indian.
Examiner	Ď	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ⚠ Widowed 4 ☐ Divorced	Armed Forces? 1		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Specif	ck, White y: W	, etc. Thite
han "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	luring most of wor	king	Own 1		ndustry
rked other tilc event, in	To Be Co	17. Father's Name (First, Middle, Last) Arden E. Borton	3	пошен	akei	18. Mother's Nam	ne (First, Middle, Kirchenb	Maiden Sumar		
m 27 is ma		19a. Informant's Name/Relationship (T) Rebecca Pfeifer —	Daughter	297 B	ng Address (Street a Lossom La costion (Name of				ia 2	4175
Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Middical Examinar must be notified at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Vicens	Removal from State Mt.	Olive	t Cemeter Name and Addres 621 Oposs	y 6-7-	2006 F tauffer	rederio Funeral	k, M	laryland le
rsicien and e burial-transit e burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	uence of):						
ittending phy or use as th	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □Yes 2 ☑ No 9 □ Unknown	d	death 3	□Ectopic pregnancy □ Other (specify)				ate of deli-	very Day Yea
pe e	ρ	Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	inderlying cause give	en in Part I.		bacco use con es 2□No		the cause of dea
ate has been si page 2 should	Completed						24a. Was autop perfor 1 Yes	an 24b. sy med? 2 No	death?	topsy findings av ompletion of cau 2□ No
ector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA Othe	200	ith <i>(Check only</i> o		her (Spec	ify)
After ti funera	Certification;	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 "	yat <br Yes 2 □ No	28d. Describe h			ral Route Numbe
nerel Director;		4 Homicide determined	building, etc. (Specify	v) wledge, dea	th occurred at the tim	ne, date and place	City or Tow	m, State) cause(s) and m	anner as	stated.
To the Funerel D completely filled in	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifler	iner: On the basis of examina and manner stated.	tion and/or in	29c. License D4547	pinion, death occu number	irred at the time, o	date and place, 29d. Date signe 6-3-200	and due	to the cause(s)
/AI.	ite	30. Name and address of person while a Yeheyis Negussie 31. Date filed (Month, Day, Year) JUN 0 6 20		Fores	, Print) t Glen Ro	ad, Silve	er Sprin	g, Mary	land	20910

Amend 1tem Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Marion Sane Day Month **Physician** 7:38 2006 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2□ F Yrs. South Carolina Director 246-01-0063 Sept. 28, 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 entrance any injury or other traumatic event, ITE Margary. 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Carrol1 Maryland Mt. Airy Director 10f Zin Code 10g, Citizen of What Country? 10e. Street and Number 21771 United States 1005 Parade Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No WWII
If Yes, Give WWII
Year or Dates: 1 Never Married 2 N Married Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Be Walter Samuel Sane Minnie Lee Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1005 Parade Lane, Mt.Airy, MD 21771 Edith Sane/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 6/6/2006 Forest City, Sunset Mem. Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service I 1621 Opossumtown Pike, Frederick, MD 21702 or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the displace, or conshock, or heart failure. List on Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 weeks disease or condition resulting in death) CONGESTIVE HEART RAILURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijbry that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transi and resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown been signed by should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown CHRONIC ROMAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RANCTOPENIA 24a. Was an this certificate has 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPKE HOSP Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Director: After 1. Atatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital within 24 hours a To the Funaraf I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/06 032171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6006H FREDORICK WALKERSUILLE MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year,

6 2006

egistrar's Signatur

32

DHMH 17 Rev 1/2001

State

Registra

MARIA D'ARBELA M.D.

JUN

5

2006

31. Date filed (Month, Day, Year)

1500 FORESTGLEN ROAD; SILVER SPRING MD 20910

32 Registrar's Signature

			1 - State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of	Health and <i>Death</i>	Mental Hy	giene	06	19324
2.	Physici /Medi		1. Decedent's Name (First, Middle, Last EDWARD J	AMES	SHECKE	LS		2. Date of De Month JUNE	Day	Year 0 0 6	3. Time of Death 11:43Р м
1	Examir		4a. Facility Name (If not institution, give FREDERICK MEMO			4b. City, Town, FREDE	or Location of De	ath	4c. County		К
	Funeral Director		210 30 4033	x 7. A	ge (In yrs. last birthday 68 Yrs.	Months Days		8. Date of Bir (Month, Da July 1	th ay, Year) 2 1937	9. Birthr Cour Ma	place (State or Foreign http: ryland
	the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County Md. Frederi 10e. Street and Number	_ck	10c. City, Town or l Frede				10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 ▼ No
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-1 show important: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injuryephother traumatic event; the Medical Examinar must be nuitled at once.	ed by Funeral Director	6009 Pleasant Dr: 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Specify:	erto Rican, etc.)	Unite	d Sta ce - Americ ck, White, y: W	ates can Indian, etc. Thite
ind 21215-0036	2 should be filed within 72 and Mental Hygiene. Is marked other then "ns sumatic event, the Medic	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	le completed) College (1-4or	5+) (Giv life. Br	e kind of work done DO NOT use retire ick Layer	during most of word) 18. Mother's N	ame (First, Middle	Const	ructi	·
Maryland	nd 2 should th and Men 27 Is marke traumatic	To	Edward James Sl 19a. Informant's Name/Relationship (7) Betty L. Sheckel		19b. Mai	ing Address (Stree		Rural Route Numb	er, City or Town,	State, Zip	
Baltimore,	Pages 1 and 2 nent of Health sut: If Item 27 I		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			osition (Name of ematory or other pla itan Crer	1	Date /4/06	20c. Location		own, State
Balt	permit. Pag Department Important: I any injuga		21. Signature of Funeral Service Licens 77444 W.	Bark	ev		H. Barb	er Funera 8, Laytor		Md.	20882
8760,	Physician physician and physician and physician and physician and physician and the physician and ph	dical Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence of): a consequence of): a consequence of):	plicalm hong	✓)	ас от юзрнасогу а	ilest,		Approximate Interval Between Onset and Death
O. Box 6	The law requires that the deeth certific ate has been signed by the ettending p cage 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc	у			te of delive	ery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death I	out not resulting in the	underlying cause gr	ven in Part I.		obacco use cont	ribute to th	ne cause of death?
al Rec		Completed							rmea!	Were auto prior to cor death? I ☐ Yes	psy findings available mpletion of cause of 2 No
on of Vital	ding Phys h. After this funeral di	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Datural 5 Pending investigation	dospital: Anpati	ury 28b Time	of 28c. Inju	ner: 4 🗆 Nursing	eath (Check only of Home 5 Residue) 28d. Describe			y)
Division	o at o ⊑	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm, s tc. <i>(Specify)</i>	reet, factory, office		28f. Location (City or Tox	Street and Numb wn, State)	er or Rura	l Route Number,
	the Hospital or within 24 hours after To the Funerel Direction Completely filled in b	Medical	one)	sicien: To the best ner: On the basis of and manner s	of my knowledge, dea of examination and/or intended.	rvestigation, in my	opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
Ì	G S P P P P P P P P P P P P P P P P P P	2	29b. Signature and title of certifier	an		B.HG	76740	70	29d. Date signer	106	
12	Sta	ate	30. Name and address of person who consider the second of	HQ 32 Regist	- 0 h	Print) 400 W	7th S	+ Fred	lerick	md	21701
	Regist		JUN 5 20	106	w B. Py						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤌 🏻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Month **Physician** Year Joyce Ann Tyson June 4, 10:24A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett Garrett Co. Memorial Hospital Oakland Oakland

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Fourty) | Min. | Months | Days | Hours | Min. | May 27,1931 Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthdav) 6. Sex Funeral 1 ☐ M 2 🕱 F 75 Director 577-38-9061 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Itams 23a or 28a-f shov per must be notified at 1X Yes 2 No Funeral Director Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Morris Ave. 21531 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner filed withIn 72 hours after 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Š Specify: White 3 Widowed 4 Divorced "natural" Completed other traumatic event, I've Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental is marked Laurence H. DeLapp Margaret Dahlstrom ٩ and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily J. Friend/Daughter f Health itam 27 i 265 Fearer Rd., Friendsville, MD 21531 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Country Side Crem. * 4 ☐ Donation 5 ☐ Other (Specify) June 5,2006 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes, P.A XX P.O. Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head railure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Kespiratory /Medical Due to (of as a consequence of) Examiner Obstructive MONZA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by failure 1 Yes 2 □ No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ependence certificate has page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

32. Registrar's Signature

SCHWALM

2006

20

31. Date filed (Month, Day, Year)

		_	For State	State	of Marylar	id / Depa	rtment of H	ealth a	and Me		ené) () (16	19326
			Registrar 1. Decedent's Name (First, Midd.	le Last)			timouto o			. Date of Death			3. Time of Death
	Physicia		Vi Van	Tran						Month	Day	Year	3:45 PM
	/Medic				(aumbor)		4b. City, Town, or	Location		May 29	2006 4c. County		3:45 P
	Examin	er	4a. Facility Name (If not institution	n, give street and	namoer)			Cocation	OI DOGUI				
			Manor Care- W		7 4 //	lant historia.	Wheaton If Under 1 Year	If Under	24 Hrs 0	. Date of Birth	Mon	tgome	ery plece (State or Foreign
	Funeral		5. Social Security Number	6. Sex 1 🔂 M 2 🗌	7. Age (In yrs. 77	Yrs.	Months Days	Hours	Min.	(Month, Day, '		Cour	ntry)
	Director	-	213-39-6205 Usual Residence of Decedent		//				M	ay 7, 1	929	Vie	t Nam
	and w	1	10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation					1	10d. Inside City Limits
	sho	5											1 ☐ Yes 2 🙀 No
	28a-1	ect	Maryland Mont	gomery		Silver	Spring 10f. Zip Code			10	g. Citizen of V	Vhat Cou	ntry?
	with the page of	Ö	11522 Charlto	n Drive			209	02		1.0	g. Onazori or i	USA	, .
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director			Decedent Ever in U	S 12.3	Vas Decedent of H	innania Ori	risis? /Specific	fy You or No	14 Bace	- Amari	can Indian.
	er de Item	nu	11. Marital Status	Arme	d Forces?	.5.	Yes, specify Cuba	in, Mexical	n, Puerto Ric	can, etc.)		k, White,	
36	s aft	by F	1 Never Married 2 Mar 3 Widowed 4 Divorce	If Yes	es 217 No , Give or Dates:		I□Yes 2☐No	Specify:	:		Specify	Asia	n
21215-0036	hour	d b			or Dates.	16a Dagge	ient's Usual Occup	ation			6b. Kind of Bu	siness/ln	duetor
ις.	"naf	Completed	(Specify only highe	nt's Education est grade comple	ted)	(Give	kind of work done of NOT use retired	during mos	st of working	'	OD, KING OF DO	31110332111	dustry
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2	led v		17. Father's Name (First, Middle	(act)	4	<u> </u>	Major	18 Moth	er's Name (I	First, Middle, M	Milita	-	
E .	tal H	Be										<i>J</i>	
3	Mer Mer Marke	٦ و	Minh Van Tran							Nguyen	-	01111 77	- 0.3.
Maryland	2 sh and Is m		19a. Informant's Name/Relation	ship (Type, Print)			g Address (Street						
2	and ealth m 27	8	Khiem Tran/ S	on	205		Cherrywo	od Di	rive,				
Ore	Og fig 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal f	rom State	cemetery, cren	sition (Name of natory or other place		_	1,	Oc. Location -	City or 10	own, State
Ĕ	Pag nent ant:		'4 ☐ Donation 5 ☐ Other (Par	klawn Me	morial Parl	2	June 2006		ckvill	e. M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Licensee			Name and Address			unoral	Home	Tna	
œ	82559		James 5	Jooly			00 Univer						MD 20901
			23a. Part1. Anter the disease, of shock, or heart failure. Lis	r complications t	nat caused the dea	th. Do not ent	er the mode of dyin	g, such as	s cardiac or r	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition										Onset and Death 2 Days
	/Medical		resulting in death)		eumonia e to (or as a conse	quence of):							2 Days
	Examiner												
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89	death certificate be executed e attending physician and of for use as the burial-transit	ക											
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ă	atter	ciat	in the past 12 months?		ive birth 2 ∏Fet regnant at time of		JEctopic pregnancy] Other <i>(specify)</i>	'			Mor	nth	Day Year
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Δ.	res that the signed by th be detache		Part II. Other significant condit	ions contributing	to death but not re	sulting in the u	nderlying cause giv	en in Part	I.	23e. Did toba	acco use contr	ibute to t	he cause of death?
Vital Records,	requires been sign hould be	d by	Supranuclear H	alsv. D	iabetes M	ellitus	3.			1 🗆 Yes	3 2 □ No	3 Prot	bably 4 Unknown
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=	Th ate pag	CO									□ No 1	Yes	2□ No
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of/	hysicia his cer I direct	2	1 ☐ Yes 2 🔀 No	Hospital:	1 Inpatient 2	-		4 <u>X</u> N		9 5 ☐ Resider			fy)
		ü	27. Manner of Death 1 Natural 5 Pend	28a. [Date of Injury Month, Day Year)	28b. Time of Injury	Wor			d. Describe how	w injury occurr	ed	
.0	Attending r death. ector: After by the funer	ati	2 Accident inves	tigation			M 1 🗆	Yes 2	- 2				
Division	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. I	Place of Injury - At I ouilding, etc. (Spec	nome, farm, str fy)	eet, factory, office		28	f. Location (Stre City or Town,	eet and Numb State)	ar or Rura	al Route Number,
	rs aff	Cer											
	To the Hospital or Att. within 24 hours after de To the Funeral Directs completely filled in by the	edical			o the best of my kn he basis of examin								
	he H in 24 he F plete	edi	one)	and	manner stated.								
	To t To t	Σ	29b. Signature and title of certif.	2 .			29c. Licens			29	d. Date signed	I (Month,	Day, Year)
)	1		•	howdle	, mo	2	D43	3121			June	1,	2006
	1		30. Name and address of perso		cause of death (Ite								
			Nurul Chowdhu	ıry, MD	15216 Di	no Dri	ve, Burto	nsvi	lle, M	1D 20866	5		
	Sta	ate	31. Date filed (Month, Day, Yea	r)	32 Negistrar's Sign	ature	ale						
	Regist	rar	JUN 2	2006	Besur .	D. 199							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:00 AM 06 Donald Vaughn 06 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Braddock Campus 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 03/12/1941 Birthplace (State or Foreign Country) **Funeral** Hours Days 1X M 2□ F 179-32-8007 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other trsumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 956 (514 Marshall Street) 21502 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after. Heelth and Mental Hygiene. tem 27 ie marked other than "naturel", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ۵ White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tire and Rubber Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Α. Vaughn Μ. McCarthy Lillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 Wilbur Way, Cogan Station, PA Karin L. Sirbaugh / daughter 17728 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: It Itel
eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 06/09/2006 4 Donation Blair Memorial Park Bellwood, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. well 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cas Woin HASHUA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Oasulopah Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-translt The law requires that the death certificate be executed loholic resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical -auso IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No is efter death.
ral Director: After this certificety land in by the funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Maturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of dea em 23a) (Type Print) nas 40M65 31. Date filed (Month, Day, Year) egistrar's Signature Registrar

		•	For Stata Registrar	State of I	Maryland		artment of Hertificate of L		Mental Hy	giene Rag. No	ZUUb	19328
	9		1. Decedent's Name (First, Middle	e, Last)					2. Date of De	eath Day	y Year	3. Time of Death
п	Physicia		Raymond	O. Von Sa	under				June	2,	2006	6:30P M
	/Medic Examin		4a. Facility Name (If not institution	, give street and numb	per)	_	4b. City, Town, or	Location of Dea	th	40.	County of Death	
			Montgomery Hos	pice - Cas	ey Hous	e	Rockvi				Montgome	ry
	Funeral		5. Social Security Number	6. Sex 7. 1 √2 M 2 ☐ F	Age (In yrs. la		If Under 1 Year Months Days	Hours Mir	. (Month, D	rth ay, Year)	9. Birthr	place (State or Foreign http:/ .inois
	Director		318-20-4035	X	79	Yrs.			Oct. 2	.3, I	926 111	.1nois
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	eation					10d. Inside City Limits
	fanyl faho ed e	ō	Maryland Montg	omery		Rockv	ille					Y∏Yes 2 ☐ No
	the N	ect	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	with 3a or		13 Clemson C	ourt			2085	0		U	.S.A.	
	72 hours after death with the Maryland natural; or Items 23s or 28s-f show dical Exact must be rediffed at	Funeral Director	11. Marital Status	12. Was Decede		i. 13.	Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (Specify Yes or N	0-	14. Race - Ameri	
ယ	or iter	교	1 ☐ Never Married 2 ☐XMarr	Armed Force ried 1 ∑Yes 2 If Yes, Give	□ No			Specify:	no rican, etc.)		Black, White,	
21215-0036	ral', c	by	3 Widowed 4 Divorced	Year or Date	_{es:} 1946·	-70	1 ☐ Yes 2 🔀 No	Specify.			Specify: Wh:	
5	72 h	Completed		it's Education st grade completed)		(Give	dent's Usual Occupa kind of work done of	uring most of w	orking		ind of Business/In	
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2	e filed within al Hygiene. I othar than ' vant, the Me	ပိ	17. Father's Name (First, Middle,	5+		1	Engineer	18. Mother's Na	ame (First, Middle		S. Govern	nment
anc	ould be fi Mental I- karkad ot katic eval	Be	·								,	
<u> </u>	2 should be and Mental Is marked raumatic ev	2	Raymond Vot			19b. Maili	ng Address (Street a		yn Rei		or Town, State, Zij	o Code)
Maryland	d 2 s th an 17 ls						Clemson Co					20872
ė,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene ittem 27 is marked other than "natural", or liems 23a or 28a-f show item 27 is marked other than "natural", and it is Medical Examinating to rigitlized at	- 3	Alice M. Von Sa	aunuei	20b. Pla	ace of Dispo	sition (Name of		Date		ocation - City or T	
<u>o</u>	ages ant of t: If if		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5				matory`or other place itan Crema		6/4/06	Alex	xandria.	Virginia
Baltimore,	permit. Pages 1 an Department of Heal Importent: If itam 2 any Injury or other once.		21. Signature of Fun ral Service	-	, .) 25	Name and Addres	s of Facility		1		
ä	Depared Important Important Information In		* Koveri L	Nell	cams	/ M	olesworth 6401 Ridge	-William Road	ns P.A., Damasc	Fune	eral Homo Maryland	e 20872
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau	used the death.							Approximate Interval Between
	Physician		Immediate Cause (Final		nal Fai	luro						Onset and Death
	/Medical		disease or condition resulting in death)	a	ras a consequ							
	Examiner		O	End	d Stage	Rena	l Disease					
	n =	ner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	т ав в волееци	enes of):						
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ő,	te be executed ysician and ie burial-transit		resulting in death) Last		ras a consequ pertens						1	
8760,	a c =	Physiclan/Medical		d								
9 X	ertific ding p	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnar	nev					23d. Date of deliv	1084
Вох	eath certific attending p I for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal nt at time of de	death 3[☐Ectopic pregnancy ☐ Other (specify)				Month Month	Day Year
Ö	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov			_ ciner (apoonly)	-				
σ.	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant conditi	ons contributing to dea	ath but not resu	liting in the u	inderlying cause give	n in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
sp.	uires sign ild be	d by							1	Yes 2	□No 3□Pro	bably 4∑Unknown
Records,	w require been si should I	Completed							24a. Wa		24b. Were auto	opsy findings available
Re	The lav ate has page 2	m C							per 1 Yes	opsy formed? 2 🌠 No	death?	ompletion of cause of
Vital		0	25. Was case referred to medica	11				26. Place of D	eath (Check only			1411-14-14
>	S 5	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2 🗆 E	ER/Outpatie	nt 3 DOA Othe	er: 4 🗍 Nursing	Home 5 ☐ Res	sidence	6X Other (Speci	(fy) Hospice
l of	Ilng Ph J. After th funeral	n: T	27. Manner of Death	28a. Date of (Month	Injury Day Year)	28b. Time of	of 28c. Injury Work	at	28d. Describe	how inju	ry occurred	
0		atic	2 Accident invest	igation			M 1 🗆	Yes 2 □No				
Division	or Attan after deat Diractor: in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	minord Zoe. Flace	of Injury - At ho g, etc. (Specify	me, farm, st	reet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Rur e)	al Route Number,
Q	itel o irs afi ral Di								<u> </u>			
	Hosp 4 hou Fune Fune	edical	(Check only 2 Medica	ng Physician: To the base I Examiner: On the base	sis of examinat	wledge, dea: ion and/or ir	th occurred at the tin evestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s e, date an) and manner as s d place, and due l	stated. to the cause(s)
	To the Hospitel or Attantwithin 24 hours after deall To the Funeral Director: completely filled in by the	Med	one) 29b. Signature and title of certific	and manne	or stateu.		29c. License	number		29d. Da	te signed (Month,	Day, Year)
N	7.¥ ₹ 8		Ch	Las Dass								
	1,114	•	30. Name and address of person	who completed as	of death /ltom	23a) (Tuno	D4245			Jun	e 5, 200	16
(87.		C. Rajogopal	0				π ₀ 01-	ON Mos-	1001		
	St	ate	31. Date filed (Month, Pay, Year) C 200C 32.F	gistrar's Signat	ture	hilip Dri	ve, UIN	ey, Mary	Tand		
	Regist		JUNU	6 2086	gistrar's Signat	D. A	1000					

			For State Registrar	State of Maryland		rtment of H			giene Reg. No.	006	193	29
	Dhysisia		Decedent's Name (First, Middle, Last)					2. Date of De.	ath Day	Year	3. Time of I	Death
	Physicia /Medic		Joseph Henry Welch					June	8	2006	5:58	A.M
	Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of De	eath		unty of Death rrett		
	ik .	, P	Garrett Memorial Ho 5. Social Security Number 6. Sex	7. Age (In yrs. la	st hirthday)	Oakland If Under 1 Year	If Under 24 H	Irs. 8. Date of Birt			place (State or	Foreign
ŧ.	Funeral Director			2□ F 92	Yrs.	Months Days		Sept. 2	20.19	13 Mar	ntrv)	1 Groigin
	Α .		Usual Residence of Decedent									
	how	_	10a. State 10b. County	10c. City	Town or Lo	cation					10d, Inside City	
	Ba-f s	cto	MD Garrett	M	t. Lal	ce Park					1 🙀 Yes	2 [] NO
	vith th	Director	10e. Street and Number			10f. Zip Code	0		•	of What Cou	-	
	a 23e	eral	1007 Wheeling Avenu	Was Decedent Ever in U.S	13 1	2155		(Specify Yes or No		ed Sta		
36	be filed within 72 hours after death with the Maryland tal hygiene. Id other than "natural", or itema 23a or 28a-f show avant, tra Madical Examinat must be untilised a	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: WWII	1	Yes, specify Cubai	Specify:	' (Specify Yes or No uerto Rican, etc.)		Black, White, ecify:		
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21	giene giene er the	Completed	12 2		County	Treas/R		r of Wills		unty G	ov.	
	be filed tal Hygi d other avant, I	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle,		mame)		
<u>Y</u> a	Men Men Marke	ဥ	Carl Brasher Welch	-: 1				G. Weimen				
Maryland	12 sh h and h and 7 la m traum		19a. Informant's Name/Relationship (Type					Rural Route Number Oakland			Code)	
o,	1 and Healt am 2		Dr. Wm. Porter Weld	20b. PI	ace of Dispo	sition (Name of		Date		ion - City or T	own, State	
altimore,	ages int of t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	toval from State		natory or other place Mem. Gdns		11/2006	Oakla	nd, MD		
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Ba	permit. Pages 1 and 2 should be fill Oppartment of Health and Mental Himportant: If Itam 27 Ia marked oth any injury or other traumatic avan <u>once.</u>		* Katherina VI	witer			1	nd St., Oa				
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death	. Do not ente						Approximate Interval Betw	veen
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ø	tificat ng phy es th		IF FFILM F				.555	177.5		1		
Box	leath certific ettending p I for use es I	an/N	230. Was decedent pregnant	. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			230	. Date of deliv Month		021
O. E.	at the dea by the ett	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5□	Other (specify)				MOUTH	Day Y	ear
P. O.	that the ed by I	P.	Part II. Other significant conditions contri	huting to death but not resu	lting in the u	nderhving cause give	en in Part I	23e. Did t	ohacco use	contribute to t	he cause of de	aath?
ds,	signed be det	d by	Congection	e Hoat	Ŧ	all re		10	Yes 2□N	lo 3 Prol	bably 4 🗀	nknown
200	w require been sig should b	lete	Missing	dial la	Faire	Low		24a. Was	an 2	4b Were auto	opsy findings a	vailable
Records,	he lav e has	Completed	rigocar	(100)	3 4 - 6	// (0		- autor	psy ormed?	prior to co death?	mpletion of ca	use of
ta	ician: Th certificete rector, pag	0	25. Was case referred to medical				26. Place of	1 ☐ Yes Death <i> Check only c</i>	2 Ko	1 🗆 Yes	2 U NO	
<u> </u>	ysici is cer direct	ToB	examiner? 1 Yes 2 Hos	pital: 1 Inpatient 2 1	ER/Outpatien	t 3 DOA Othe	N. 67	g Home 5 ☐ Resi		Other (Speci	fy)	
0	Attending Physician: r death. sctor: After this certifics by the funeral director, I		27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	28c. Injury Work	at c?	28d. Describe I	how infury o	ccurred		
Sio	eath. or: A	catle	2 Accident investigation				Yes 2 □ No					
Division of Vital	i Si ta	Certification:	3 Suicide 6 Could not be determined	 Pface of fnjury - At ho building, etc. (Specify 		eet, factory, office		28f. Location (: City or Tox		umber or Run	a <i>l Route Nu</i> mb) <i>01</i> ,
	spital cours neral filled		29a. Certifier 1 ☐ Certifying Physic	ian: To the best of my know	vledge, death	occurred at the tim	ne, date and pl	ace, and due to the	cause(s) an	d manner as s	stated.	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examine one)	r: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my op	pinion, death o	ccurred at the time,	date and pla	ace, and due t	o the cause(s)	
	To the within To the comp	Σ	29b. Signature and title of contifier			29c. License	number			igned (Month,	Day, Year)	
•			1 VIL			D239	79		6.8.0	5		
	C4/17			pleted cause of death (Item			1 1 1	MD 01==	0			
-10			Dr. Robert A. Gora 31. Date filed (Month, Day, Year)	1ski, 311 N. 32. Registrar's Signal		treet, Oa	Kland,	MD 21550	U			
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State of Maryland / Department of Health and Mental Hygiene. U U U 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 2006 6:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Facility Name (If not institution, give street and number) Examiner Yo Montgomeri tomad Kebecco If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 26, 1 Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F 122-16-0889 82 Yrs New York Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 X No Director Virginia Fairfax McLean 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. of A. 22102 1201 Old Stable Road "netural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 No If Yes, Give Year or Dates:1943-45 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I important if item 27 is marked other than "netural", or its any injury or other traumatic event. Its thing Examits 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 <u>ک</u> White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Pauline Mehring Jacob Edward Hollinger ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Wood/Daughter 1201 Stable Road, McLean, VA 22102 Barbara Wood Patton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 5 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Leesburg, Virginia Union Cemetery 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudoun Funeral Chapels 158 Catoctin Circle, SE, Leesburg, VA 20175 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heath failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Obstructure Pulmering Discuse Physician 54EARS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events Due to (or as a consequence of) inding physician and use as the burial-transit The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) should be detached ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 X No 1 Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 155,560 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.V 100093,7 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) 2333 S. Nash Street, Arlington, Virginia 22202 Byrne, M.D. gistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State of	f Marylar		rtment of F tificate of		d Mental	Hygie Reg	2 U	06	19331	
	Dharaini		1. Decedent's Name (First, Middle, I	.ast)					2. Date of Month		Day	Year	3. Time of Death	
н	Physicia /Medic		Howard LaFayette	Whitt					June	2		2006	9:10 A M	
	Examin	er	4a. Facility Name (If not institution, g	ive street and nur	nber)		4b. City, Town, o		Death		4c. Count			
			10910 Rawley Rd 5. Social Security Number 6.	Sex	7. Age (In yrs.	last hirthday)	New Mar		Hrs. 8. Date of	of Birth	Frede		pplace (State or Foreign	_
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	yland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits	
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	or 28	Director	10e. Street and Number				10f. Zip Code	,		10g	. Citizen of		untry?	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or Items 23a or 28e-f ehow eny injury or other treumatic event, the Medical Evanities must be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Amarried 3 Widowed 4 Divorced	Armed Fo	2 X No /8	li li	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 2 No	an, Mexican, F	Puerto Rican, etc	:.)		ack, White		
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, Maryland 21215-0036	and 2 shealth and n 27 is m		19a. Informant's Name/Relationship Opal Lee Whitt -			1091	g Address (Street		New Man	ket,	, Mary	/land	21774	
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	To the H within 24 To the F complete	Medi	one)		ner stated.		29c. Licen						n, Day, Year)	_
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	10		30. Name and address of person w Daniel Snow, M.	D. 19	703 Exe	cutive	Print) Park Ci	rcle, G	ermanto	wn, l	Maryl:	and 2	20874	_
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 6	2006	gistrar's Sign	nature	berte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** KICCARD PHILLP WHALEN JUNE 2006 12:201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11117 Hoffman Drive Montgomery Germantown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∭**M 2□F Months Days Hours Min Director 110-18-3802 DEC. 2 1926 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examiner must be rediffed at 1 ☐ Yes 2√ No Maryland | Montgomery Germantown Direct 10f. Zip Code 10g. Cilizen of What Country? 10e. Street and Number 11117 Hoffman Drive 20876 U.S.A. deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Deceden!'s Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Heelth end Mental Hy Importent: if Item 27 is marked oth any injury or other treumatic event 2008. Be 2 John Whalen Gladys Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11117 Hoffman Drive, Germantown, Maryland 20 ce of Disposition (Name of Date 20c. Location City or Town, Slate <u> Rosemary Whalen - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematorium 6/6/06 Alexandria, Virginia ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Peneral Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home Rosert 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. PROSTATE Immediate Cause (Final METASTATIC Physician YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or se a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 TYes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. D scribe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation completely filled in by the within 24 hours efter deat 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA GUPTA MD 8926 WOOD YARD ROAD # 201, CLINTON,

29c. License number

29d. Date signed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1000

			For State Registrar		State of M	aryland / De <i>C</i>	partme <i>ertifica</i>			Menta	ıl Hygien Reg. N	6000	19333
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	/Medic		Jame			ns					JUNE		8:40A M
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	deat	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Dec		ispanic Origin? (S n, Mexican, Puer	Specify Ye	s or No-	14. Race - Ameri	
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Maryland	should be fund Mental to marked of umatic even	2	James		Watkins				Reva	М.			
a S	d 2 sho			ame/Relationship (7								or Town, State, Zip	
	Health tem 27 other tr		20a. Method of Disp		- Brother	20b. Place of Di	sposition (N	ame of	Court, M	Date		Location - City or To	21770 own, State
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trai			neral Selvice Licen		.)	22 Name 101esw	and Addres	s of Facility Williams	s P.A	., Fund	eral Home	
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	/Medic	_	DOROTHY	WILSON						1, 2006			0354	M
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	188 He	Director	10e. Street and Number		OZIVE1	10	of. Zip Code			10g. Cit	izen of What	t Country?	?	
	3a or		18301 GEORGIA AVENU	F APT 211			20832			II	.S.A.			
	death	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. Was I	Decedent of H	spanic Origin?	(Specify Yes	r No-	14. Race - A			
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3	atura er E		15. Decedent's	Education	16	a. Decedent's	Usual Occupa	ation		16b. K	ind of Busine	ess/Indust	try	
2	within 72 ene. than "na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) Cotlege (1-4or 5		(Give kind : life. DO N	of work done o OT use retired	during most of v ()	vorking					
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2	Hygie other	e	17. Father's Name (First, Middle, La	st)				18. Mother's N	lame (First, Mi	ddle, Maider	Sumame)			
Maryland	should be ad Mental marked c matic evi	To B	GEORGE	DAVIS				LILLIAN		TR	ENT			
	short and N	_	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	dress (Street a	and Number or	Rural Route N	umber, City o	or Town, Stat	te, Zip Co	de)	
Ξ	alth a		JANINE W. DIXON/DAU	GHTER	1	9424 PYI	RITE LAN	E, BROOKE	VILLE, M	ARYLAND	20833			
alumore,	E S E E		20a. Method of Disposition		20b. Place cemet	of Disposition	(Name of	e)	Date	20c. L	ocation - City	or Town,	, State	
	Page 11 September		1 ☐Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			WN MEMOI			07/2006	ROCK	VILLE, 1	MARYLA	AND	
	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic evonce.		21. Signature of Funeral Service Lie	ensee		22. Nar	ne and Addres	s of Facility						
Ď	Page a		1 (Imanda)	Kudewi	2	HINES 11800	S-RINALD: O NEW HAI	I FUNEŔAL MPSHIRE A	HOME, I	NC. ILVER S	PRING, I	MARYLA	AND 209) 04
,000,	Physician /Medical Examiner per partial-transit p	icai Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a complete to	a consequence	Arh e of): che e of):		nc),					terval Betwe	
.O. DOX 00	death certifics e attending ph d for use as t	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf dea		pic pregnancy er (specify)				23d. Date of Month	defivery Day	y Ye	9ar
, SD	es tha	þ	Part II. Other significant condition	s contributing to death bu	ut not resulting	in the underly	ving cause give	en in Part I.			use contribut			_
necords,	e law requir has been si je 2 should	Completed							- 3	Was an autopsy	prior	to compte	findings av	vailable use of
		S								performed? es 2.21√No	deat	n? Yes 2⊡	□ No	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysicien: is certific director,	Be	25. Was case referred to medical examiner?						Death (Check o	nly one)				
	Physic this c	2	1 ☐ Yes 2 No		nt 2 ER/C			# Idaising	g Home 5□			Specify)		
	ding f	ation:	27. Manner of Death 1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of fnjur (Month, Day	Year) 28b	. Time of Injury M	28c. Injun Worl	yat k? Yes 2 □ No	28d. Desc	ribe how infu	ry occurred			
	P = 2 = 0	Certification:	3 ☐ Suicide 6 ☐ Could no determin		ury - At home, (Specify)	farm, street, f	actory, office			on (Street ar r Town, State	nd Number o	r Rural Ro	oute Numb	er,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination a	and/or investig	ation, in my of	pinion, death or	ccurred at the t	the cause(s) and manne d place, and	r as stated due to the	d. e cause(s)	
	To th within Fo th comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Da	te signed (M	lonth, Day	(, Year)	
	ID		I Sichael K-	- m)			MIS 03	50410		Qui	ne 1	, 20	06	
	lu		30. Name and address of person w	and manner sta	eath (Item 23a	Type, Print	lia o	ben	M)	2013.				
in	se l'a Sta	ato.	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	- 11 -	w -	7		2010.				
	Regist		JUN 5	2006 Angue	w Is	Signal								

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 19335

		1- For State Registrar		Certific	ate of	Death		Re	eg. No	00 1200
Physicia Medical Examii	ın/	1 Decedent's Name (First, Middl KELLYE	(le,Last) CHARIS	E	YOV	JNG		2. Date of Dead Month May 26, 2	Day Year	3. Time of Death 1245 hrs
		4a. Facility Name (if not institutio 8 Russell Avenue # 40	-		41	o. City, Town, or Lo Gaithersburg	ocation of Death	1	4c. County of Montgome	
Funeral Director		5. Social Security Number 514-78-3892	6. Sex 7. Age	(In yrs last birt	hday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	1.		9. Birthplace (State or Foreign Country) KS
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examines, must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 8 Russell 11. Marital Status 1 X Never Married 2 Mr.	12. Was Decedent E Armed Forces? 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 3 1 Yes 2 1 Yes 3 1 Yes 4 1 Yes 3 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 4 1 Yes 5 1 Yes	0 6 ver in U.S. X No leted) 16a) 191 20b Place 6	13. Was If Ye 1 Decedent' during mo: Proc. D. Mailing to Eight of Disposition	Decedent of Hispa s, specify Cuban, Mores 2 X No Business (Street a Cie St. Street a Cie St	877 anic Origin? (Si Mexican, Puerto specify n (Give kind of 10 NOT use ret alystMother's Name Marga and Number or 1	pecify Yes or No Rican, etc.) work done ired) e (First, Middle, Maret Gr Rural Route Num	U.S.A 14 Race - White, 6 Specify 16b. Kind of Busin O.	10d. Inside City Limits 1 XYes 2 No Country? American Indian, Black etc. Black ness/Industry H.A. State, Zip Code) J 07302
Baltimore, permit Pages I an Department of Heal Important: If iten Injury or other tra			r complications that caused the on each line.	me death Do no	cory or other or or or or or or or or or or or or or	er place) Arl Svc: me and Address o 16 N. Wa	s 5 fFacility S ashing	nowden ton St	Alexa Funera Rockvi	ndria, VA 1 Home, PA 11e,MD20850
50, te be executed ysician and buttal - transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to deep leg	vein thron	nbosis					
1876 tifica ing ph	by Physiciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Uni Part II. Other significant condit	Pregnant at til	me of death	Oth	ol death 3	Ectopic pregna	23e. Did to	2 No 3	Day Year Ite to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use	To Be Completed	25 Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital 1 Inpatient		utpatient	3 DOA		ng Home 5	med? dea 2 No 1 Residence 6	Yes 2 No Other. Scene
Division of spital or Attending Plours after death neral Director: After filled in by the funeral	Certification:	3 Suicide 6 Cou	estigation		Time of Inj		s 2 No			or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical ((Oncon only	Physician: To the best of my aminer: On the basis of examinand manner stated	_			death occurred a		and place, and due	to the cause(s) (Month, Day, Year)
	ate	30. Name and address of person Margarita Korell MD. 31. Date filed (Month Pay, Year)	Assistant Medical E	xaminer Signatur	111 Pe	nn Street, Bal		21201		
Regist		JUN 2	2006 Sere	No All	1900					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** 2008 Zatz 7:16P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace | Months | Days | Hours | Min. | Aug. 22, 1907 | Russia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 F 133-44-8304 98 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Madical Examinar must be notified at Director Rockville MD 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20852 10500 Rockville Pike #317 or iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 6 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mudical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Menasha Shaindel (Unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martin Zatz -Son 4853 Cordell Ave. Apt. 1009 Bethesda, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Benoval from State Lincoln Park Cemetery 5-28-06 Warwick, R.I. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee -0 1091 Rockville Pike Rockville, MD 20852 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner o the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Insufficiency, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4∑☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 2X No director Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1X Yes 2 □ No 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending efter death.

Director: Afi 1 Tes 2 No investigation М 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours effer To the Funerel Dir 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only onel 29b. Signature itle of cert 29c. License number 29d. Date signed (Month, Day, Year) D26571 5-26-06 30. Name and address of p tho completed cause of death (Item 23a) (Type, Print) Irving Mizus, MD 10215 Fernwood Rd. #401 Bethesda, MD 20817 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUN 2006 Registrar

		State of Maryland / Department of Health and Men 1- State Registrar Certificate of Death	6000 1001
Towards, To	8 .550 ⁻⁵	11910101	Reg. No. Date of Death 3. Time of Death
Physi /Med		WALTER FRANK ANUSZEWSKI	Month UNE 17, ZOOE 2:20 PM 4c. County of Death
Exam	iner	ANUE ARUNDELMEDICAL CENTER ANNAPOLIS	ANNE ARUNDEL
Funera Directo	_	213-64-1946 15 49 Yrs.	Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND
aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 ₩ No
th the M or 28a-f e notifie	Director	MD. ANNEARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death wi	Funeral		Yes or No- in, etc.) 14. Race - American Indian, Black, White, etc.
0036 hours after death with the Maryland turel; or Items 23a or 28a-f show at Examinan must be notified at	þ	3 Widowed 4 Divorced Year or Dates:	Specify: WhITE
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours aff thealth and Mental Hygiene. Item 27 is marked other then "natural", or other traumatic event. In M. digut Example other traumatic event.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
laryland 21 2 should be filed w and Mental Hygis is marked other t aumatic event. In	Be	17. Father's Name (First, Middle, Last)	SERSTATE GOVT. rst. Middle, Maiden Surname) SILC VIRVA
Maryland d 2 should be filter th and Mental H EZ 1 e marked oth	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Co	oute Number, City or Town, State, Zip Code)
or Leath of Health fitem 27		20a. Method of Disposition 1 Burial 2 Ocremation 3 Removal from State	20c. Location - City or Town, State
Pag nent unt: I	à	4 Donation 5 Other (Specify) HNATOMY GATS KG15TRY 6-19-	06 HANOVER, MO
Balti permit. Departn Importe		Daugherty Family Funeral Home 2601 Mountain Road - P.	asadena, MD. 21122
Physicia	n	23a. Pa.M. Effer the disease, or complications the save of the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Interval Between Onset and Death
/Medica		resulting in death) Due to (or as a consequence of):	
rted	Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	
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687 rtificate ng phys	Medicai	G. G. G. G. G. G. G. G. G. G. G. G. G. G	
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rds, P.O. I			23e. Did tobacco use contribute to the cause of death? 1
Records, he law requires to hes been signed age 2 should be to	Completed by	Diabetes mellity	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
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n of N ng Physi fter this c	on: To	The second of th	5 Residence 6 Other (Specify) Describe how injury occurred
Division of Vital Rewithing Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide determined Accident investigation M 1 Yes 2 No 28e. Place of Injury : At home, farm, street, factory, office 28f. 28f. Could not be determined Could not be building, etc. (Specify) Could not be	Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel of within 24 hours at To the Funerel Completely filled is	edical Ce	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and	
To the I within 2. To the I complet	Med		29d. Date signed (Month, Dey, Year)
		MO 10057635	June 17, 2006
			mpli mo 21401
1999/1997	State strar		

			For State Registrar	State of Ma	aryland / D	epartment of H Certificate of I	lealth and N <i>Death</i>		ene200	5 19338
	Dhuaiai		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		JOHN			ARNICK		June	13 200	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of De	ath
					SPITAL					N/A
	Funeral			11√2 M 2□ E	(In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	ear) (inthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	/	2			Nov. 27,	1933 M	aryland
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Man Fish	tor	Maryland Bal	timore			Dundal	k		1 ☐ Yes 2 ☑ No
	r 28e	Directo	10e. Street and Number			10f. Zip Code	2011002		. Citizen of What C	Country?
	th wit		7918 Diehlwood	Road			21222		United :	States
	eep dee	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Am Black, Wh	
92	or it	y Fu	1 Never Married 2 Married	1x Yes 2 □ N		1 ☐ Yes 22©ANo	Specify:		Specify:	nte, etc.
2-003	be filed within 72 hours after deeth with the Maryland tal Hygiene id other then "natural", or items 23a or 28e-f show event, the Medical Exablear must be indified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						White
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	filed Hygi Sther ent, I		17. Father's Name (First, Middle, Last	7 Years	I A	ttorney	18. Mother's Nam	ne (First, Middle, Ma	Law iden Sumame)	
a	id be ental ked c	To Be	John Arnick				Joseph	ine Galli	ard	
Maryland	12 should be filed within h and Mental Hygiene. Fis marked other then " Iraumatic event, Ira Me.	_	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Street a				Zip Code)
	end 2 Balth a n 27 is		Mrs. Joanne Arr	nick (Wife)	7918 Diehlwo	ood Road	Dundalk,	Maryland	21222
ē,	ite.		20a. Method of Disposition	7.	20b. Place of	Disposition (Name of r, crematory or other place	:e)	Date 20	c. Location - City o	r Town, State
altimore,	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 3 ☐ Other (Speci			Lawn Cemeter	· 1	/2006	Baltimore	e, Maryland
ā	permit. Page Depertment of important: If eny injury or once.		21. Signature of Funeral Service Lice	nsee		22. Name and Address Duda-Ruck	ss of Facility	Home of	Dundalle	Tna
<u> </u>	82.59		1000.20	<u> </u>				undalk, M		21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory arres	L,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	META	STATIC	LUNG CA	NCER			Onset and Death
	/Medical Examiner		resulting in death)		consequence o					. 1401011-1
	Examiner		Sequentially list conditions,	b						
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•	xecut and- al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	f):				
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9	ficate g phy s the	edicai		d						
Box	death certifi e attending I d for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		a 🗆 s			23d. Date of de	elivery
o.	0 0 0	icia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
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	res that igned b	by F	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ğ	w require been si should t							1 ☐ Yes	2 □ No 3 □ P	Probably 4 Winknown
ပို	law r las be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u>~</u>		Con						performe	d? death?	s 2 No
/ita	sician: The law s certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?					th (Check only one)		
5	Physic this o	ဦ	1 ☐ Yes 2 No	Hospital:		patient 3 DOA Othe	4 Nursing n	ome 5 Residence		ecify)
Division of Vital Records,	ing After uner	lon	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day		jury Worl		28d. Describe how	injury occurred	
S	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	OB Place of Injur	Int - At home far	m, street, factory, office	Yes 2 □No	28f Location (Street	at and Number or E	lural Route Number,
<u> </u>	207	Certification:	4 Homicide determined	building, etc	. (Specify)	m, street, factory, office		City or Town,	State)	idrai Aodie Number,
	spits nours nerei		29a. Certifier 1 Certifying Pl	hysician: To the best of	of my knowledge,	death occurred at the tim	ne, date and place,	and due to the caus	se(s) and manner a	s stated.
!	To the Hospital of within 24 hours at To the Funerei D completely filled in	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination and ted.	Vor investigation, in my op	pinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	To tro	Σ	29b. Signature and title of certifier	0 10		29c. License	e number	_	. Date signed (Mon	
			· cardyn,	Varle	MEDICI	DR RES	-000	Ju	ne, 13, 3	2006
1	11		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	Type, Print)	W W 10 C)		do 4	1
	011		31 Date filed (Month Day Your)	IMC VOHNS HO	resignatura	TIAL, 600 NOB	m wolfe ste	eet, Balting	ex, MCIRY KU	nd 21287
	Sta Registr		CAROLYN DARLEN, 31. Date filed (Month, Day, Year) JUN 2 0 2	006 January	v M	poste				
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		•	For State Registrar	State	of Ma	ryland		rtment of H	lealth and Death	Mental Hy	ygiene Rag. No.	006	19339
1, 1	Physici	an	1. Decedent's Name (First, Mic							2. Date of D Month 06		2006	3. Time of Death 09:34 pM
	/Medio Examin		Mary P. Avere 4a. Facility Name (If not institute)		number)			4b. City, Town, o	or Location of Deat			inty of Death	03.3тр
	LAditist		Upper Chesape	ake Medica	al Ce	nter		Bel Air				ford	
	Funeral Director		5. Social Security Number 219-07-3116	6. Sex 1 ☐ M 2 ☐ X F	7. Age		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Birth Day, Year) 9 1912	Coun	lace (State or Foreign try) Y
	D ×		Usual Residence of Decedent 10a. State 10b. Cour	nh/		10c City	, Town or Lo	cation				11	0d. Inside City Limits
	with the Maryland a or 28a-f ehow Le natilied at	ō	MD Harf	•			Air	oution					1 ☑ Yes 2 ☐ No
	the N	rect	10e. Street and Number	or d		DCI	7111	10f. Zip Code			10g. Citizen	of What Coun	itry?
	3a or	Funeral Director	609 Yankee Do	odle Briv	ρ			21014			U.	S.A.	
	death me 23	nera	11. Marital Status	12. Was D		ver in U.S	S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N	No- 14. F	Race - Americ Black, White,	
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land	nd 2 should be fith and Mental H 27 ie marked of traumatic eve	To Be	Anthony Avere							a Unknov			
lan.	2 sho and ie my		19a. Informant's Name/Relation		ما سام	مده ط			and Number or R				Code)
0,0	of Health item 27		Mary L. Heckno	er, Grando	iaugn	-	_	dTIKEE DO sition (Name of	odle Dr.	Date		2 TUT4 on - City or To	wn. State
14 06 A altimore, Marylan	Pages nent of I ant: If its ury or o		1 ⊠ Burial 2 □ Crematic 4 □ Donation 5 □ Other		m State	CE	emetery, crei	natory or other pla Cemetery	·	19 2006			Maryland
Balt	permit. Page Department Important: if eny injury o		21. Signature of Funeral Servi	ce Licensee					ord Rd.,		1000		
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	/Medical Examiner		resulting in death)	Due	to (or as	a consequ	ience of).	CALCITO		VC 110			
		er	Sequentially list conditions, if any, leading to immediate	b. Due	lu (ui da i	a consequ	интон от).						
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00	that the de ed by the detached	hys	9 Unknown	9L]Ur	known				***	-			
YOUR ds, F	S E B		Part II. Other significant cond	itions contributing to	o death bu	at not resu	ulting in the u	nderlying cause gi DISEAS (van in Part I.		d tobacco use o		ne cause of death? ably 4 Unknown
Cords	iaw requii as been s 2 should	olete	NESCEL	disease		,,,,,	/		- 1	24a. Wa		b. Were auto	psy findings available
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Ma(1	Physician: Th this certificate ral director, pag	Be	25. Was case referred to med examiner?	Hospital:					26. Place of De				
70	Phys r this ral dir	2	1 Yes 2 No	28a. Da	npatie	ry	ER/Outpatier 28b. Time o	IL SEL DOA	4 🗀 Nursing i	dome 5 ☐ Re	e how injury oc		v)
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7	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		(Check only 2 Medi	fying Physician: To cal Examiner: On th	e basis of	examinal							
	To the I	Medical	one) 29b. Signature and title of cer		anner sta	Dept.		29c. Licen	se number		29d. Date sig	gned (Month,	Day, Year)
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	in		30. Name and address of pers	son who completed	ayse of d	eath (Item	23a) (Type,	Print) O	aul Ct	vest	*/-	1	
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٠	Sta Regist	ate rar	31. Date filed (Month, Day, Yo		. Registra	ar's Signa	ture A	back	/	,	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Anton Anderson 2006 15, 2:00P M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 7, 192 Birthplace (State or Foreign Country)
 VA **Funeral** 1□M 2(XF Months Days Hours Director 212-42-9203 85 1921 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show may injury or other treumstic event, the Madical Examinant be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane #HR124 21228 Be Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Tyler Anton Nannie Sanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy Greene / 115 Chesapeake Avenue Annapolis, Maryland 21403 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 19, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 2006 Brooklyn Park MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee Park A Karrera Mo13571 Second Avenue SW GLen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 3 month OL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 AGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8, perFH, 856,6/20/06 TT State of Maryland / Department of Health and Mental Hygiene) 1 - For Stete Registrer Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear Physician SR June 2:01 Louis BETHLANE 200h GARLAND /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA HOSPITAL UNION MEMORIAL BALTIMORE 8. Date of Birth6/18/1956 9. Birthplace (State or Foreign (Month, Day, Year). If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□F 220.64. 4018
Usual Residence of Decedent Director 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State ir then "natural", or iteme 23a or 28a-f ehow The Medical Examinar must be motified at 1 Ves 2□No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 USA 119 CATOR AVENUE Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Heelih and Mental Hygiene. Importent: if item 27 is marked other then "ns any injury or other traumatic event, Ita Madia once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CABLE TECHNICIAN 11 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be /IINSLEY BERTHA GREEN 1HOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ST. BALTIMORE 20c. Location (DAUGHTER) 604 N. APPLETON LATRICE DANIELS MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06.24.06 ARBUNUS BALTIMURE 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE PLINERAL SERVICE 5151 BAND NATU PIKE, BAND MD 21229 21. Sign ture of Funeral Service Licenses langhn 23a. Part1. Entaine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-transit Idney that initiated events resulting in death) Last Due to (or as a cons = uence of): Division of Vital Records, P.O. Box 68760, Stage Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year 4 Pregnant at time of death To the Hospital or Attending Physician: The law requires that the der within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No pervente 25. Was case referred to medical Be 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier AT 2438946 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial MARITA MIKE, MD 31. Date filed (Month, Day, Year) 3 Registrar's Signature Branke State JUN 2 0 2006 1 Cost Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10e, perFH e856.6/20/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JUNE Day 2006 **Physician** 12:30 AM vonne /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months 1 ☐ M 2 🗷 F Yrs. 219-26-9364 28/194 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Completed by Funeral Director 11+more 10e. Street and Number Norfolk 10g, Citizen of What Country? 10f. Zip Code 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married Yes 1 ☐ Yes 2 1 No Specify Black 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) maker NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FORDES GEORGE. ORIS ၉ 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Battimore MD 21216
20c. Location - City or Town, State arlise 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Prandallstown, MI HORK 4 ☐ Donation 5 ☐ Other (Specify) 106 22. Name and Address of Facility Valida C. Greene Funeral SVC 5151 Balto Natl Pike, Baltimore, MD 21229 21. Signature of Funeral Service Licenses areo ne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a nonsequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1□ Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Records, Vital o

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intent of Item 27 is marked other than "naturel", or Items 23s or 28s-1 show

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

Department of Health a important: If Item 27 is eny injury or other traigness.

Physician

/Medical

Examiner

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within 24 hours after death To the Funeral Director:

physician

Pervenel or Attending Physician: Division To the Hospital

State Registrar

LIM, BOON P. M. D 31. Date filed (Month, Day, Year) JUN 2 0

29b. Signature and title of ce

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSI 32 Registrar's Signature OSLER DRIVE, TOWSON, MARYLAND 21204

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

06

06-04229

Horace I. Boyles, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental

o or raine in Black machine		
Department of Health and Mental Hygiene	2000	10010
Certificate of Death	 2006	7343

	1- For State Registrar		Certifica	te of Death		J. No.	00 1934
Physician/ Medical Examine	r HOKHU	E I BOYLO	23, JR.		June 18, 20	Day Year)06	3. Time of Death 1403 hrs
	4a. Facility Name (if n	iot institution, give street and nun ial Hospital	nber)	4b. City, Town, or Locat Baltimore	ion of Death	4c. County of D	/t
Funeral Director	5. Social Security Nur 213-32- Usual Residence of D	1086 XM 2 F	7. Age (In yrs. last birth	**	Under 24Hrs 8. Date of Birth ours Min.		Birthplace (State of oreign Country)
ath with the Maryland items 23a or 28a-f show any sat be notified at once.	10a. State 10	N/A	10c. City Jown	ti MOCE			10d. Inside City Limits 1 Yes 2 No
n with the Maryland ms 23a or 28a-f she be notified at once eral Director		RA/ Woeth	Rd.	10f. Zip Code	8	g. Citizen of What	4.
after de	3 Vidowed	2 Married Armed Fo 1 Yes 4 Divorced If Yes, Give Year or Dates:	2 No	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ican, Puerto Rican, etc.)	14. Race - A White, e Specify: L	merican Indian, Black, tc.
5-0036 iled within 72 hours. Iled within 72 hours. I other than "nature the Medical Exami	15. Decedent's Educ	cation (Specify only highest grad dary (0-12) College (1-		pecedent's Usual Occupation (Cuming) most of working life. DO I	NOT use retired)	16b Khd of Busin WAVEA TRUTI	egs/Indivistry
21 be fill mtal I riked ent,	B HOKA	CE BOULES	3 S.C.		ther's Name (First, Middle, Mi	10041	3
MD and 2 sho salth and 2 sho sem 27 is raumati	20a. Method of Dispo		daugntee 20b. Prace o	Mailing Address (Street and Horizon) To Disposition (Name of cemeter and or other place)	Number of Rural Route Number Date	20c. Location - Cit	State, Zip Code by or Town, State
Baltimore permit Pages 1 a Department of He Important: If it	1 Burial 2 4 Donation 5 21 Signature of June	Cremation 3 Removal from Other Specify: eral Service Licensee	om State White	22. Name and Address of Fa	6-20-06 acility 505 PJ1, C	G. CAU DAUL	PONNA GJE I HOME
Physician	23a. Fart I. Enter the	disease, or complications that ca one cause on each line.	aused the death. Do no	t enter the mode of dying, such	as cardiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Medical	Immediate Cause (Fi or condition resulting	nal disease in death) a. Gastrointes	tinal hemorrhage consequence of):				Death
ž	Sequentially list cond if any, leading to imm	nediate Due to (or as a	cancer metastation consequence of):	to left adrenal with ero	sion of gastric wall		
A neit	cause. Enter Underling (Disease or injury that events resulting in de	at initiated C.	consequence of):				-
= 5 61		d AMENDED					
Box 68760, e death certificate be exe the attending physician a ed for use as the burial -	UNPENDED IF FEMALE: 23b. Was decedent proposition 12 months? 1 Yes 2 No. Part II. Other significations 2 months 2 months?	regnant in the 1 Live b	ant at time of death 5		ctopic pregnancy	23d Date of del Month	livery Day Year
O. Bo	Part II. Other signific	cant conditions contributing to		in the underlying cause given			te to the cause of death?
ds, P equires the een signer ould be d				,,,,,,	24a. Was a	n 24b. Wer	Probably 4 Unknown re autopsy findings available
	25. Was case referred	nd to medical		26 Place of D	autops perform 1 ✓ Yes 2 eath (Check only one)	ned? deat	r to completion of cause of th? Yes 2 No
F Vital Physician or this cert al directo	examiner? 1 ✓ Yes 2	No Hospital: 1 1	npatient 2 🗸 ER/O	utpatient 3 DOA Othe	Nursing Home 5 F		Other:
ion of Vi tending Physi eath. or: After this the funeral dir		28a. Date (Month 5 Pending Investigation	of Injury , Day,Year)	Fime of Injury 28c. Injury at 1 Yes		ow injury occurred	
Divisital or Attins after direct lied in by	1 Natural 2 Accident 3 Suicide 4 Homicide	6 Could not be determined (Specify)	e of Injury - At home, fa	rm, street, factory, office buildir	ng, etc. 28f. Location (St or Town, Sta		or Rural Route Number, City
Division of North Hospital or Attending Physician 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Check only 1	Certifying Physician: To the besidedical Examiner: On the basis of and manner s	of examination and/or in				
F 3 F 3	29b. Signature and to	itle of certifier		29c. License nur O.C.M.E		June 19, 200	(Month, Day, Year)
25	30. Name and addre	ss of person who completed caus ID. Assistant Medical I		Penn Street, Baltimore,	MD 21201		
Star Registra		UN 2 0 2006 32. Re	strar's Signature				
DHMH 17 Rev 1/200		2 5000	OR OR	IONAL	-		

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certif	ficate of De	eath		eg. No.	06 1931
Physici		Decedent's Name (First, Middle,Last) Allan Edwa	na DI-			2. Date of Dea Month		3. Time of Death
)		4a. Facility Name (if not institution, give street and num		chowicz 4b.Ci	ty, Town, or Location of De	June 13, 2	2006 4c. County of Deat	1242 hrs
		8 Baltistan Court			sedale		Baltimore Co	
Funeral Director			7. Age (In yrs. last	· · ·	Inder 1 Year If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bi	
Director		216-58-4481 1X M 2 F	52	Yrs.	onurs Days Hours	Sept.	30,1953	^{puntry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
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th the Maryland 23a or 28a-f sho	Director	10e. Street and Number		10f.	Zip Code		0g. Citizen of What Cou	Intry?
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eath wittems	Funeral	11. Marital Status 1 Never Married 2 Married Armed For	processy	13. Was Dec If Yes, sp	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
after de ul", or	by Fu	3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 Yes	2 x No specify:		Specify:	White
215-0036 be fill grid the Maryland mid Hygiener mid Hygiener mid Hygiener mid Hygiener when chart than "natural", or tiems 23a or 28a-f she ent, the Medical Examiner must be notified at once	eted b	15. Decedent's Education (Specify only highest grade		a. Decedent's Us	ual Occupation (Give kind working life, DO NOT use	of work done	16b. Kind of Business/	Industry
36 nin 72 ii. ii. than "dical.]	plet	Elementary/Secondary (0-12) College (1-4	_ ′		al Operator	retired)		lanufacturin
5-0036 ted within 7 tygiene. other than	Comple	17. Father's Name (First, Middle, Last)	S			me (First, Middle, I	W. R. Gr	ace
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and 2 should lealth and Mere ten 27 is man traumatic even	7	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addr	ess (Street and Number	or Rural Route Nun	nber, City or Town, State	e, Zip Code)
ages I and 2 shount of Health and Ptr If item 27 is rother traumatic		Mrs. Judy Blachowicz (W 20a. Method of Disposition		20 Ta1	ister Court Name of cemetery,	Rosedale Date	e, Maryand	21237
altimore, mit. Pages I ar partment of He pportant: If ite		1 X Burial 2 Cremation 3 Removal from	n State crem	natory or other pla	ice)		20c. Location - City or	Town, State
Baltimo permit. Page Department o Important: injury or ott		4 Donation 5 Other Specify: 21. Signar re of Funeral Service Licensee	Sacre	ed Ht. o	f Jesus Cem.	6/17/200	6 Dundal	k. MD
E P P W		Wischael I Meiser		1922	nd Address of Facility RUCK Funeral Wise Ave. I	Junaalk.	Marviand 2	nc. 21222
ysician Medical		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.	sed the death. Do	not enter the mod	de of dying, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Intraoral Sho						Death
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8760, tificate be on physicial as the buria	/Medical	7.11.21.02.0	tcome of pregnance	-				
	- E I'	23b. Was decedent pregnant in the past 12 months?	h	₂ Fetal dea	th 3 Ectopic preg	nancy	23d. Date of delivery Month	v Day Year
, P.O. Box 68' res that the death certifi signed by the attending be detached for use as!	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	t at time of death	5 Other (S	pecify)			
O. E at the d by the stacked		Part II. Other significant conditions contributing to d		ting in the underly	ing cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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cords, law requir has been s	Completed					24a. Was a		topsy findings available ompletion of cause of
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ital Rec ician: The l s certificate l rector, page	Be	25. Was case referred to medical examiner?			26.Place of Death (Chec	ck only one)		
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ivisi or Att after de Direct in by	ifica	2 Accident Investigation Jun 13, 20 3 Suicide 6 Could not be 28e. Place of		38 hrs farm, street, facto	pry, office building, etc.	28f. Location (S	treet and Number or Run	al Route Number, City
		20a Cartifier	Townhouse / F			or Town, St 8 Baltistan C	^{ate)} ourt, Rosedale, M	D
To the II within 24 To the Fu	dica	(Check only one) Medical Examiner: On the basis of and manner and	xamination and/or	eath occurred at to r investigation, in	he time, date and place, and my opinion, death occurred	nd due to the cause I at the time, date a	e(s) and manner as startend and place, and due to the	ed. cause(s)
	Σ	29b. Signature and title of certifler		2	9c. License number		29d. Date signed (Mon	th, Day, Year)
	-	30. Name and address of names ut	V		O.C.M.E.		June 14, 2006	
b		30. Name and address of person who completed cause of Susan Hogan MD. Assistant Medical			eet, Baltimore, MD 2	1201		
Sta Registi	_		trar's Signature	heil	,			
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1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** June 12, 2006 11:45a [™] Bragaw Margaret Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Wesley Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 XF Yrs. 86 3, 1919 Washington, D.C. Director 577-01-5876 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or then "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1X Yes 2 No Director Virginia Alexandria Alexandria 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 N. Pickett St., Condo 905 22304 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store 12 Manager other 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Hent: If Item 27 is marked oth Sager Gladys Mae Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 N. Pickett St., Condo 905, Alexandria, VA. 22304 Marie B. Michael (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Baltimore Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 6/14/06 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) @ Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Approximate interval Between Onset and Death 23a. Part: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metoslate Concer Source undelen Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical ettending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 ☐ Yes 2/EHNo Nursing Home 5 Residence 6 Other (Specify) After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Scentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ins rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 7:40A M JERROLD KELLEY COOK June 18, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **BROADMEAD** Cockeysville Baltimore County 8. Date of Birth (Month, Day, May 23, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 90 Director 216-12-5625 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examiner must be multified at 1 ☐ Yes 2 No Director Maryland Baltimore County Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "naturel, or lier 1 Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Documentary Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Films & Video Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas M. Cook, Jr. Nathalie J. Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 Is any injury or other treu 67 Brewster Circle, Hanover, PA 17331 Douglas M. Cook (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Green Mount Crematory 6/20/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functial Serve Lagsee Awardin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Approximately 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 1266 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and the for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2□ No 2 2 No 1 Yes Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Jurising Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: To the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

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ERROLD

f death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician /Medical **Examiner** Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any july or other traumatic event sons.

Rhysician

/Medical

Examiner

Directo

Completed by Funeral

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Director

al Hygiene.
I the then "natural", or items 23s or 28s-f ehow in the then "natural", or items 23s or 28s-f ehow vent, the Madical Examinar must be notified at

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 2 Certification:

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23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 X Natural

29a, Certifier

Medicai

State

Registrar

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

M.D.

28a. Date of Injury (Month, Day Year)

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JUNE 2006 10

HARBOR HOSPITAL

31. Date filed (Month, Day, Year) JUN 2 0 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACHANI PALNITKIR.

			1_ For State						d Mental Hy	/giene	2006	19349
			1 - State Registrar Amend #31 1. Decedent's Name (First, Middle, L	Per DVR G8	56 6/	20/68 ⁿ	ifficate of	Death	2. Date of De	Reg. No		I S Town (See 1)
	Physici	an	Robert						Month	Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gr		cence			Vers or Location of De	eath 6	4c	County of Deat	12 100 05
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	Funeral		Social Security Number 6.			st birthday)	If Under 1 Year Months Days	If Under 24 F	Irs. 8. Date of Bir in. (Month, Da	rth	9. Birt	hplace (State or Foreign
О	Director		225-38-4635	1 X M 2□F	73	Yrs.	Wiorith's Day's	Tiouis W	June 3	,193	3	VA VA
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary -1 eho	tor	MD Anne A	Arunde1		G1er	Burnie					1 ☐ Yes 2 No
	r 28s	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
	th wit	aiD	530 Munroe Circ	Le			210	61		IJ	.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces? 1 Yes 24	Ever in U.S	. 13. W	as Decedent of Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- T	14. Race - Ame Black, White	
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yla	2 6 8 G	2	William C. Diver					<u> </u>	Lena Mit			
Maryland	12 12 18		19a. Informant's Name/Relationship		<i>.</i>				Rural Route Numb			ip Code)
	Hea Hea the		Mrs. Betty Jean 20a. Method of Disposition	Divers/ wi	20b. Pla	ce of Disposi	tion (Name of	1	Slen Burn		D 21061 ocation - City or	Town. State
Baltimore,	9°= 5		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Qther (Spec				e Crema	. 100	ne 22,			
ij	in the second		21. Signature Fune at Service Lice			22.	Name and Addr		006 ingleton		vensvill	
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	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):						
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		Med	IF FEMALE:				., ., .					
Вох	eath certi attending for use a	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal d	leath 3□E	ctopic pregnanc	у		1	23d. Date of deli- Month	
P.O.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at 9☐Unknown	time of dea	ith 5⊡ (Other (specify) _				MOUTH	Day Year
	law requires thet the death cert as been signed by the attending 2 should be detached for use a		Part II. Other significant conditions	contributing to death bu	it got result	ing in the und	leriving cause or	ven in Rart I.	23e. Did t	obacco u	se contribute to	the cause of death?
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Ö	s been shou	Completed		Rheima	toil	1	A Allani	110	24a. Was	an	24b. Were aut	opsy findings available
Re	o + 5	mo			000	v	1 -20000	<u> </u>	autor perfo	osy ormed?	prior to co	ompletion of cause of
ital	lan: rtifice stor, p	BeC	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only o	2 No	1 L Yes	2□ No
<u>></u>	Physiclan: r this certific ral director,	To	examiner? 1 ☐ Yes 2 10 No	Hospital: 1 Inpatier	nt 2 🗆 El	R/Outpatient	3□ DOA Ott		Home 5 ☐ Resid		3 ☐Other (Spec	fy)
טע	Ing P	:uo	27. Manner of Death ↑☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injur	y occurred	
sio	Attending ir death. ector: After by the fune	cati	2/ Accident investigation 3 Suicide 6 Could not to					Yes 2 □No				
Division of Vital Records,	i or Attend efter death Director: ,	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At nom . (Specify)	ie, tarm, stree	it, factory, office		28t. Location (S City or Tox	Street and vn. State	d Number or Rui)	al Route Number,
	Hospital 24 hours e Funerel [letely filled		29a. Certifier 1 Certifying P	hysician: To the best of	f my knowl	edge, death o	occurred at the ti	me, date and pla	ce, and due to the	cause(s)	and manner as	stated
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examinatio	n and/or inve	stigation, in my	opinion, death oc	curred at the time,	date and	place, and due	to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	0 0 0	1.	0	29c. Licens	se number	,	29d. Date	e signed (Month,	Day, Year)
	4		Jayoshue	Here	1-71.	7	1 1	4659	6	6	117/0	6
			30. Name and address of person who	completed cause of de		3a) (Type, Pr	int) 7 41.TT	MAPE	WASHI	MC	IOH Me	d centre
* 77	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			# do		173 M f	170	1017 . 120	Gren Bern
	Registr		C112/06 J	UN 2 0 8006	14	dist.	15 A					1411

		1 - For State Registrar	State of Mar	ryland /				ealth a Death	ınd M	- '	giene /	2006	19350
Physici /Medic		1. Decedent's Name (First, Middle, Las	mory							2. Date of Dea Month	Day	ZOO 6	3. Time of Death 10:05A M
Examin		4a. Facility Name (If not institution, give		10-5 p 11	tal	4b. City,	Town, or Bis	Location o	f Death	;	4c. C	Ounty of Death	
Funeral Director		200 10 110	9X 7. Age	(In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 11-25	191		place (State or Foreign RGINIA
the Maryland 28s-f ehow	ior	Usual Residence of Decedent 10a. State 10b. County MD • N/A		10c. City, Tov	or Loc				17				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the last or 28s-	Funeral Director	10e. Street and Number 2123 W. BALTIMOR	E, ST.		11110	10f. Zip	Code 21223	3			_	en of What Cou	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland by given by given the most the most the most be notified at event, the Medical Examinar must be notified at	y Funera	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No If Yes, Give		ff		cify Cubar			cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White	, etc.
in 72 hours n "natural", Asolical Ex	Completed by	3 XWidowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra-	Year or Dates: lucation de completed)	168	a. Deced	ent's Usua	al Occupa	ition Juring most	of workir	ng		d of Business/Ir	LACK
Sahould be filed within 72 in and Mahalla Hygiene. Is marked other than "naturatic event, the Medical	Be Com	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden					ONGSHOREMAN n Sumame)	
should nd Men marke umatic	To	DOUGLASS DEMORY 19a. Informant's Name/Relationship (7)	ype, Print)	19	b. Mailing	g Address	(Street a			DOLES I Route Numbe	r, City or	Town, State, Zi	p Code)
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tra		SYLVIA HILL (DAUG 20a. Method of Disposition 1 Burial 2 Oremation 3 O	Removal from State	20b. Place o	of Dispos ery, crem	atory or o	ne of ther place	9)	D	ate	20c. Loca	LAND 21 ation - City or T	own, State
permit. Pa Departmen Importent: eny injury		4 Donation Other (Specify 21. Signature of Funeral Service Licen)	ARBUTU D. HIB	NER2.	Name an	d Addres	s of Facility	PHI	LLIPS F	UNERA	AL HOME	MARYLAND , P.A.
Physician		23a. Part1. Exter the disease, or compshock, of heart failure. List only of mmediate Cause (Final	plications that caused the cause on each line		not ente		e of dying	g, such as				E, MARY	LAND 21217 Approximate finterval Between Onset and Death
/Medical Examiner		disease or condition resulting in death) Sequentially fist conditions,	Due to (or as a			mo	112 4						
cate be executed oblysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a										
ath certification of the control of	cian/Me	in the past 12 months? I Live birth 2 Fetal death 3 Lectopic pregnancy								23	23d. Date of delivery Month Day Year		
quires that the de	d by Phys	Part II. Other significant conditions or	ontnbuting to death but	not resulting	in the un	derlying c	ause give	n in Part I.			es 2 🗆		the cause of death?
The law requir ate has been si page 2 should I	Completed									24a. Was a autop perfor	sy	prior to co	opsy findings available impletion of cause of
Physicien: The this certificate his director, page	To Be (25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{ZNO} \)	Hospital:	2 ER/O	utpatient	3[] DC	Othe	_		(Check only or	ne)	□Other (Special	
r Attending Ph or death. rector: After th by the funeral	ertification:	27. Manner of Death 1 Auturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Time of Injury	M 2	8c. fnjury Work 1 🗆 Y		2	8d. Describe h			
To the Hospitel or Attendium virtin 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	4 Homicide determined	building, etc.	(Specify)						City or Tow	n, State)		al Route Number,
To the Hospitel or within 24 hours afte to the Funerei Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phyone 2 ☐ Medical Exemology 29b. Signature and title of certifier	ysician: To the best of liner: On the basis of e and manner state	xamination a	ge, death nd/or inve	estigation,	at the time in my op License	inion, deat	f place, a h occurre	d at the time, o	date and p	lace, and due t	o the cause(s)
1 M 1 00		· Ja Ma	of CS	A,	M				950			signed (Month,	, 2006 TO, MD.
3	145	30. Name and address of person who of the control o	(1	Sm 1-	(Type, F	Print)	100	W.	B	1270.	ST	BA	TO. M.D.
Sta Registr		IIIN O O O	~	La	4	N							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per fh 9856 6-20-06 yt
State of Maryland Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		irtment of t tificate of			ne 2006	19351
	Physic	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medi			1995				JUNE	8 2000	10:28PM
	Examir	ner	4a. Facility Name (If not institution, giv		it	4b. City, Town,	or Location of Dea		4c. County of Dea	th .
1	Funeral		5. Social Security Number 6. S	NG TON BLVI	rs, last birthday)	If Under 1 Year	ALTIM If Under 24 Hr	S. 8 Date of Birth	9 Ric	thplace (State or Foreign
. 76	Funeral Director			□M 28\$F	64 Yrs.	Months Days			1942 500	TTT CAROLINA
	yland		10a. State 10b. County	10c.	City, Town or Loc	cation		2		10d. Inside City Limits
	e Marfa	ctor	MARYLAND 1)/A	BA	LTIMO	ORE (-174		1 A Yes 2 □ No
	death with the Maryland me 23a or 28a-f show f must be notified at	ai Dire	100. Street and Number	GTON BLVE	#115	10f. Zip Code	2123	10g	. Citizen of What Co	ountry?
	eme	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of I	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show many injury or other traumatic event, the Madical Experiment must be notified at any Injury or other traumatic event, the Madical Experiment must be notified at angle.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		☐ Yes 2 🗖 No		11021, 010.7	Specify:	ACK
5-("natu	iete	15. Decedent's Ed (Specify only highest gra		(Give I	ent's Usual Occup and of work done	during most of we	orking 161	b. Kind of Business	Industry
2121	within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ONOT use retire			1/50	. /
	Hygin Hygin Sther	CC	17. Father's Name (First, Middle, Last)		1 01	MERA-7		ime (First, Middle, Mai	VERIZ	ON
an	lid be lental rked c	To Be	TAMES	BR 00	CKINGI	TON	LOR	RAINE	F	2001/
Maryland	and N	-	19a. Informant's Name/Relationship (Address (Street	and Number or F	lural Route Number, C	ity or Town, State, 2	Zip Code)
_	and 2 ealth m 27		THOMAS CLAR	K (NEPHEU	1300	WASH	INGTON	BLVD. 115	BALTO, +	10.21230
ore	t of H If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	 Place of Dispos cemetery, crem 	ition (Name of atony or other pla	ce)	Date 200	. Location - City or	Town, State
Baltimore,	t. Partmen		4 ☐ Donation 5 ☐ Other (Specification)) M	1T. Z10,		ERY 06-	13-06 2	ANSDOW	NE, MB.
Bal	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other trea		21. Signature of Funeral Service Licer	N. Willia	15 0	Name and Addre	SHITT.	BROWNS	TR. FUNE. ALTO, MI	RAL HOME
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not ente	r the mode of dyn	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a NowTE	My	300001	m In	CALVINIA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
160	***	76	Sequentially list conditions,	b. Due to (or as a cons		man	1 Dist	M.E.		2 40m-25
J	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	250 10 (01 20 2 00110	04001100 017.					
V	exection and rial-tra	Еха	resulting in death) Last	Due to (or as a cons	equence of):					
68760	The law requires thet the death centificete be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	edicai	(d	·					
	ing ph		IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3 🗆 8	Ectopic pregnancy	y		23d. Date of deli	
	ires thet the death cer signed by the ettendin d be detached for use	Physician/A	1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	f death 5	Other (specify) _			IVIONUI	Day Year
, P.O	thet the by detail		Part II. Other significant conditions c	ontributing to death but not r	esulting in the und	dertying cause giv	ren in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	quires n sign	d by	TUPE I DAGET	4	11175					obably 4 Unknown
000	sw requir s been si 2 should	Completed	PERIPHERM VASC	VLDR DUFA	AC.2			24a. Was an	24b. Were au	topsy findings available
Ä	The lav	Luo.			3.0			autopsy	? prior to death?	ompletion of cause of
of Vital	Physician: The k r this certificete ha aral director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 🔀 ath (Check only one)	010 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	21,000
) T	hysion this co	ပ	1 Xves 2 □ No		☐ ER/Outpatient	3□ DOA Oth	er: 4 🗆 Nursing l	dome 5 A Residence	6 ☐Other (Spec	ify)
	of the	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28d. Describe how in	njury occurred	
Division	il or Attending after death. Director: After d in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		home form street		Yes 2 □No	29f Location (Change		10
ρ	ital or A	Certification:	4 Homicide determined	building, etc. (Spe	cify)			28f. Location (Street City or Town, St	ate)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my k siner: On the basis of exami and manner stated.	nowledge, death on nation and/or inve	occurred at the time estigation, in my o	ne, date and place pinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	7 /		Date signed (Month	
•	1) level	Jan		')	3697	+ (06/13/2	W6
	H		30. Name and address of person who of David O, Nyanjom	completed cause of death (It	em 23a) (Type, P	Patrix L	Paul	C.1. # n	41	506 25 MD 21044
Sec. S	Sta	te	31. Date filed (Month, Day, Year)	JZ. He istrar s Sig	nature	4	iarkuay,	Juite "200	Columbi	3 MD 21044
3	Registr	***	JUN2 n 2	006 Jenne	K A	racke				
DHI	MH 17 Rev 1/20	001	2 0 -	1-1-1-1	~ 19					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 James 10:00 AM 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner K Ktowne ALTIMORE rac 6. Sex 12 M 2□ F If Under 24 Hrs Date of Birth (Month, Day, 8/30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 69 Months Days Min. Hours 216-32-340 Yrs Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itama 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 3€XNo Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3025 Parktowne Rd. 21234 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes **2√X**No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No δ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: white 'naturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 city assessor other Baltimore City permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi important: If item 27 is marked other eny injury or other treumatic event, I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) James Fowler Catherine L. Espey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alyn Fowler - spouse 3025 Parktowne Rd. Parkville, MD 21234 20b. Place of Disposition (Name of cometery, crematory or other place)
Green Mount
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 20 Cremation 3 Removal from State June 20, 4 ☐ Donation 5 ☐ Other (Specify) 2006 Baltimore 8800 Harford Signature Ineral Service L Parkville, MD 21234 Evans Funeral Chapel 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** MHEROXLACTIC CARDIOVASCACAR MAN745 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ğ in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 ☐ Yes 20 Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: ို 200No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of beath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Learning Physician: To the bast of my knowledge, Jeath decurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier To the 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "ichael milli W SOFFE abods SUCTOBER 31. Date filed (Month, Day, Year) State JUN 2 0 2006 Registrar

06-04176

Please Type or Print in Black Indelible Ink

erry W. Frazier		State of Marylan 1- For State Registrar		rtment of tificate of		d Mental H		200)6 1935
Physicia Medical Examir		Decedent's Name (First, Middle, Last) Terry W. Frazier					2. Date of Deat Month June 16, 2	Day Year	3. Time of Death 1616 hrs
		4a Facility Name (if not institution, give street and numb Union Memorial Hospital	er)	4	b. City, Town, or I Baltimore	Location of Death		4c. County of Dea	
Funeral Director		212-50-2168 ₁ X _{M 2} F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min		th(MM/DD/YYYY) 9. 8 21,1949 Ma	
ow any		Usual Residence of Decedent 10a. State 10b. County NI/A	1	Town or Location					10d Inside City Limits 1 XXYes 2 No
th the Maryland 23a or 28a-f show any notified at once,	Director	Maryland N/A 10e. Street and Number		Baltimor	10f. Zip Code	· · · · · ·	10	Og. Citizen of What Co	
with the surface or no 23a or be notified		11.30 Falls Hill Drive Apt 11. Marital Status 12. Was Decede	ent Ever in U.		212 Decedent of Hisp	panic Origin? (Sp			rican Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	by Funeral	1 Never Married 2 Married 1 Armed Force 3 Widowed 4 X Divorced If Yes, Give Year or Dates.	2 XX No	1	Yes XX No	specify		Open,	iite
136 thin 72 hours aftere. than "natural", edical Examiner	Completed	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4	- 7.0	during mo	's Usual Occupation of working life. Cruction	DO NOT use reti		16b. Kind of Business Construc	
		17. Father's Name (First, Middle, Last)	1		1	8.Mother's Name		Maiden Surname)	
D 2121 should be fi and Mental 7 is marked	Η I	Frank Reid 19a. Informant's Name/Relationship (Type, Print)		1	Address (Street	and Number or F	Rural Route Num	n Frazier nber, City or Town, Stat	
Z pud 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2	-	Fammie Warner Step-Daughte 20a Method of Disposition	20b. P	Place of Disposi	tion (Name of cem	netery,	Date 4E	Baltimore 20c. Location - City o	<u>- </u>
Baltimore, permit Pages I al Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from 4 Donalipn 5 Other Specify: 21 Signature of Funeral Service Liceage	State Pa		cemetery		21/2006		e, Maryland
		Lynn B. Henss		1363	I Falls	Road, B	altimore	Home, Inc.	
Physician /Medical Examiner		23a. Part I. Inter the disease, or complications that caus failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone			e mode of dying, s	such as cardiac o	r respiratory arre	est, snock, or heart	Approximate Interval Between Onset and Death
for emission of		or condition resulting in death) Due to (or as a co Sequentially list conditions, b.	sequence of	f):		S			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause unsease or much material				J.			
and Transit	al Exa	events resulting in death) Last Due to (or as a co			147 OF	6 6 100 106			
68760, certificate be executed anding physician and ease the burial - transit	Medical	X UNPENDED AMENDED -			,perME,g85	6,6/30/06	TT	23d. Date of deliver	N
		23b. Was decedent pregnant in the past 12 months?	at time of dea	2 Fet	al death 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year
P.O.	全	Part II. Other significant conditions contributing to de	ath but not re	esulting in the u	nderlying cause gi	ven in Part I.		bacco use contribute to	
cords law requ	Completed						24a. Was a autops	an 24b. Were a prior to death?	utopsy findings available completion of cause of
Vital Rec ysician: The I his certificate I director, page	Be Co	25. Was case referred to medical examiner?				of Death (Check	1 ✓ Yes 2 only one)	2 No 1 Y	es 2 No
n of Vital ling Physician: After this certifi funeral director,	ှု	1 Yes 2 No 109 Inpa 27. Manner of Death 28a. Date of	niury T	ER/Outpatient 28b. Time of In		Other Nursin		Residence 6 Othe	er;
- # ^ Z	ation	1 Natural 5 Pending Fnd 6/16	/2006	Fnd 3:30	Pin	es 2 No	unknown		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification	4 Homicide determined (Specify) for		ome, farm, stree parking 1	t, factory, office bu	ilding, etc.	28f. Location (S or Town, St reltimore,	treet and Number or Rate 1100 Blk. I	ural Route Number, City Falls Hill Driv
To the Hos within 24 h To the Fur completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of e and manner state	xamination ar						
F 3 F 5	ž	29b. Signature and title of certifier			29c. License O.C.M			29d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who completed cause of Ling Li, MD Assistant Medical Examin		·	t, Baltimore, N	/ID 21201			
Sta Regist				re Appare					

			For State Registrar	State of Ma	-		rtment of H <i>tificate of l</i>			liene 0 0	5	19354
	Physicia	an	Decedent's Name (First, Middle, La. Earl Ar	thur Fran	ıklin S	r			2. Date of Dea Month June	Day Yea		3. Time of Death 8:00am M
	/Medic Examin	al .	4a. Facility Name (If not institution, giv		KIIII, D.		4b. City, Town, or	Location of Deat		4c. County of D	eath	o.ooan
	Examin	eı	109 Franklin Ave				Syke	esville		Carı	ro11	
	Funeral Director		213 20 1039	ex 7. Age	9 (In yrs. last birtl 76	hday)_ /rs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year) 9.1 1929	Birthplac Cou <i>ntry</i> , MD	e (State or Foreign)
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation				10d.	Inside City Limits
	e Mar	ctor	MD Ca	rroll		Syke	esville_					1 Tes 2 No
	or 26	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What	_	?
	s 23s	era	109 Franklin Ave	nue	Ever in II S	13 W		784	Specify Yes or No-	14. Race - A		Indian.
036	filed within 72 hours after death with the Maryland Hygiene. kther than "naturel", or Items 23a or 28a-f show ont, the Medical Everal or must be retiffed a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			Yes, specify Cuba	Specify:	specify Yes or No- to Rican, etc.)	Black, W		
2-0	72 ho natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	(Give k	ent's Usual Occupa	during most of wo	rking	16b. Kind of Busine	ss/Indus	stry
121	I within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		<i>o noт use retired</i> efrigerat		anic	Refriger	atio	on
p	al Hyg I other	BeC	17. Father's Name (First, Middle, Last						me (First, Middle,			
<u>yla</u>	ould to Menti	2	William H. F						rude C.		7: 0	
Mar	nd 2 sh alth and 27 is m ir treum		Mrs. Trudy Brown							r, City or Town, Stat esville,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Eventret net must be rectified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special				ition (Name of atory or other place Mem. Gar	dens 6	Date 19 2006	20c. Location - City Marriotts		
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Lice	Lauge	L MO076	4 HA Sy	Name and Address AIGHT FUN kesville	ERAL HOM MD 217	ME & CHAP 784 (410)	PEL (Box 1 -795-1400	95)	
	Physician /Medical Examiner	ılner	23a Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nigry)	a Due to (or as	a consequence of	6 4 of):		g, such as cardia	c or respiratory ar	est,	In	pproximate terval Between nset and Death
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence o	of):						
P.O. Box 6	death cer e attendir od for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Da	ay Year
	tw requires that the s been signed by th ? should be detache	by Pt	Part II. Other significant conditions	contributing to death b	-	the un	derlying cause give	en in Part I.		bacco use contribut	e to the d	N .
ord	requir	eted	/ 4 6	46 1-40	W in				4.0			ar collection
of Vital Records,	The la ate has page 2	Completed							24a. Was a autop: perfor	sy prior	to compl 1?	r findings available letion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- :	off post Oth		ath (Check only or	0.00		
of		: To	1 ☐ Yes 2 No 27, Manner of Death	1 inpatie		tpatient ime of	28c. Injun	y at	-	ence 6 Other (5	Specify)	
	Attending in death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Y⊖ar) Ir	njury	Wor					
Division	i Diri	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, fai c. (Specify)	rm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural R	oute Number,
	ne Hospitel or 124 hours afte ne Funerel Dir netely filled in	ledical (29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st		-17	and the state of the same	and the same of the same of the same of	and the second s		-1	/ - \
)	To the P within 24 To the F complete	Me	29b. Signature and fittle of certifier	Sourt	in.		29c. Licens	e number	2.	29d. Date signed (M.	onth, Day	y, Year)
	10		30. Name and address of person who	completed cause of completed cause of completed cause of completed cause of complete cause of complete cause of completed cause of c	leath (Item 23a) (Туре, Е	Print) WEST	reet li	restmini	ster, mi	à	71157
	Sta Regist		31. Date filed (Month, Day, Year)	006 32 Registr	ar's Signatore	Spa	arte					

			For State Registrar	State of Marylan	•	rtment of			giene	2006	19355
	Physici	an	Decedent's Name (First, Middle, Last)	Δ	<u> </u>	1		2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)	<u> </u>	4b. City. Town	n, or Location of Deat	JUNE		County of Deal	17:00 AM
	Examin	er	1315 Vander	bilt Rd.		Be	1 Air			HARFO	
	Funeral Director		5. Social Security Number 6. Set	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day			h v, Year)	l Co	hplace (State or Foreign untry) SACHUSETTS
	D		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				7,,	10d. Inside City Limits
	a-f ehc	ctor	MD Harford	l Be	el Air	•					1 □ Yes 2√01/No
	with the	Funeral Director	10e. Street and Number 1315 Vanderbil	+ D.3		10f. Zip Code	014		10g. Citiz	ten of What Co	untry?
	Jeeth Tee 23	erai		12. Was Decedent Ever in U.	S. 13. V		of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No-	. 1	USA 4. Race - Ame	
036	within 72 hours after deeth with the Maryland ene. than "natural", or teme 23a or 28a-f ehow fa Madical Examiner must be notified at	É	1 Never Married 2 Married 3537idowed 4 Divorced	Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates:		Yes, specify C		to Hican, etc.)		Black, White Specify: W	_{e, etc.} hite
15-0	n 72 ho "natur edicel	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occ kind of work doi OO NOT use ret	ne durina most of wo	rking	16b. Kin	nd of Business/	Industry
212	d withi	Somp.	Elementary/Secondary (0-12) 12	College (1-4or 5+) 5 +	Teac				Ec	ducati	on
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event. It a Medical Examiner must be notified at ance.	To Be (17. Father's Name (First, Middle, Last) Francis X. McN	Jamara				me (First, Middle, Haley	Maiden S	Sumame)	
Mar	id 2 sho lith and ! 27 ie ma		19a. Informant's Name/Relationship (Ty Bruce Good - s			-	et and Number or Ri erbilt Ro		-		
Baltimore,	es 1 an of Hea litem? r other		20a. Method of Disposition 1 □ Burial 2€ Thermation 3 □ F	C	lace of Dispo: emetery, cren	sition (Name of natory or other p		-		cation - City or	
Ĕ	t. Pages rtment of rtant: If It		4 □ Donation 5 □ Other (Specify)			tery	20	006		imore	
e Ba	Department of the partment of		21. Signatural Fundral Service Licens		Ë	vans F hapel-	dress of Facility Funeral - Bel Air	3 Nor	ewpo	rt Dr Hill,	MD 21050
ij			23a. Part / Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ications and caused the death ne cause on each line.	h. Do not ente	er the mode of o		*	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	o ga	w ra	ulmo			15 0000
ï	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	A I Ymy	inally					4420
	nd transit	Examiner	Cause (Disease or injury that initiated events	· ·							
760,	icate be executed physician and	cal Ex	resulting in death) Last	Due to (or as a conseq	uence of):						
89			JE FEMALE.	J. =							
Box	Attending Physician: The law requires thet the death certifica refault. If death. Sector: After this certificate hes been signed by the attending phy the funeral director. page 2 should be detached for use as it by the funeral director.	by Physician/Med	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregna Other (specify)			2	3d. Date of deli Month	very Day Year
<u>о</u>	het the od by th detach	Phys	9 ☐ Unknown Part II. Other significant conditions conditions		ulting in the ur	nderlying cause	given in Part I	23e. Did to	bacco us	se contribute to	the cause of death?
rds,	en sign		picheter N	ellites, as	spm, 6			1 🗆 Y	es 2 d	\$610 3□Pr	obably 4 Unknown
Vital Records, P.O.	The law re te hes be age 2 sho	Completed	- prout care,	ovaria (non			24a. Was autop perfor 1 \(\text{Yes} \)	sv	prior to death?	topsy findings available completion of cause of 2 No
ita	ctor. p	BeC	25. Was case referred to medical examiner?					ath Check only or	nej		
	Physic rthis corral dire	ို	1 Yes 2 No	lospital: 1 Inpatient 2 28a. Dale of Injury	ER/Outpatien		Other: 4 Nursing F	lome 5 Resid			cify)
ion	ath. r: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	V	Nork? □Yes 2□No		,		
Division of	声름드	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al he building, etc. (Specif	ome, farm, sire	eet, factory, office	ce	28f. Location (S City or Tow	itreet and m, State)	Number or Ru	iral Route Number,
	To the Hospital or within 24 hours effect of the Funerel Direction completely filled in	edicai	29a. Certifier 1 D Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in m	e time, date and place by opinion, death occu	e, and due to the durred at the time, d	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1///	1	29c. Lice	ense number	:	29d. Date	signed (Month	n, Day, Year)
,			30. Name and address of person who co	ompleted cause of death (Item	7 n 23a) (Tyne	Print)	17415		0//	9/06	
	1/		arun	Mclew un	611	- More	e Mand (nd Br	el j	RIV. 1	121014
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 0 20	32 Registrar's Signa	ty A	arli					

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			giene eg. No.2 0 0 6	19356
			1. Decedent's Name (First, Middle, La.	st)				2. Date of Deat		3. Time of Death
	Physicia /Medic		Hattie Gre	garn				June	12 200	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Logation of Dea	th	4c. County of De	
			Genesis Homeu	rord Cen	fer		ene			
	Funeral		Social Security Number 6. S	ex 7. Age □M 2 X F	(In yrs. last birthday)	Months Days	If Under 24 Hrs Hours Min	(Month, Day	: Year) C	rthplace (State or Foreign country)
	Director		219-22-3873	-A-	96 Yrs.			05 29	9 10	NC
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ō	MD NA		Baltin	nore				1 XYes 2 No
	the 288-	Director	10e. Street and Number		Darcin	10f. Zip Code		1	log. Citizen of What 0	Country?
	3a or		6000 Bellona A	WA			21212		U.S	λ
	death ms 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No-		erican Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married	1 Tes 2 N	0	1 ☐ Yes 2 🛣 No	Specify:	to ricall, etc.)		
8	ural',	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:						Black
5	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Marical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of Busines	s/Industry
12	within one.	m	Elementary/Secondary (0-12)	College (1-4or 5	+)	omestic			Dri	vate
2	e filed withi al Hygiene. I other than vent, itte M		12th grade 17. Father's Name (First, Middle, Last	<u>na</u> Unknown		Mescic		me (First, Middle, i	14 14 0	Unknown
ano	of be control of the	Be c	,,	UIIKIIOWII					,	UIIKIIOWII
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Marylan it and Mental Hygiene. 77 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Modical Examiner must be notified at	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or A	lural Route Number	r, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is ner trau		Gail A. Johnso	n-Grandda	aughter 2	Spinne	rs Ct	IR. Rane	dallstow	n, Md 21133
Baltimore,	一丁る女		Gail A. Johnso 20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	:0)	Date	20c. Location - City of	r Town, State
E			1 X Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Special		-	Memori		9/06	Arbutus,	Md
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	1500	2	2. Name and Addres	ss of Facility			
m	99 5 6 8		+ Coleume .	H. Jhum	pour	March F/ 1300 Wab	H West	e. Balt	imore, Mo	3 21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End	Stane De	mentic				Onset and Death
	/Medical		resulting in death)	a	a consequence of):					
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-	sit ad	lne	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as t	a consequence of):					
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of);					
8760,	ate be executed hysicien and the burial-transit			4						
687		edical		0			-			
Вох	leath certifica attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		75-4			23d. Date of d	elivery
	death e atte	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		□Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	Day Year
P.0	at the de by the a	hys	9 Unknown							
Ś	The faw requires that the death certific the bas been signed by the attending p age 2 should be detached for use as	by F	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	ınderlying cause gıv	en in Part I.			to the cause of death?
ord	w require been si should?	ted						1 L Y	es 2□No 3□I	Probably Juni own
of Vital Record	e taw r has be	Completed						24a. Was a autops	sy, prior to	autopsy findings available completion of cause of
E B		Co	_					perform 1 \(\text{Yes}		es 20 No
/ita	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or \	eath (Check only or		
of	S S D	2	1 Yes 2 No 27. Manner of Death	1 L Inpatie		nt 3 DOA	4) Trursing		ence 6 □Other (Sp ow injury occurred	ecify)
	ling After fune	lon	1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	Year) Injury	Wor		200. 00001100 111	on injury observed	
Division	or Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could not b	28e. Place of Inju	ury - At home, farm, st				treet and Number or I	Rural Route Number,
Div	after after Direct	Certification:	4 Homicide	building, etc	c. (Specify)			City or Tow	n, State)	
	Hospital 24 hours Funeral etely filled			hysician: To the best of miner: On the basis of						
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	one)	and manner sta						
	To the I within 2 To the I сощрет	Σ	29b. Signature and title of certifier			29c. Licens	e number) 1) 5942		29d. Date signed (Moi	nth, Day, Year)
•	n		My	A CONTRACTOR OF THE PARTY OF TH		-	w .		June	14 2006
	' /)		3 Name an address of person who	completed cause of d	eath (It im 23a) (Type	, Print)	onnt	tan R. 1	4 0 - 11.	0 2.330
			31. Date filed (Month, Day, Year)	32-Ratistra	ar's Signature	van BIL	O LOB.	50-5 ">601	nuive, 100	21257
	Sta Regist	ate rar	JUN 2 0	2006	w It is	carle			Amore, M	

State of Maryland / Department of Health and Mental Hygien 2 0 6 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:50 A M 2006 Sanford 6 14 Givens /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 795 Jennie Drive Severn Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 5-7-1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₹M 2 ☐ F 236-24-4196 82 Yrs. Director W Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDAnne Arundel 1 ☐ Yes 2 🕅 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or itams 23a or the Madical Examiner must be 795 Jennie Drive 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic Diesel Mechanic other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill ont of Heelth and Mental Hit: If item 27 is marked oth y or other treumatic eventy. Samuel Fleet Givens Ruby Othel 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 795 Jennie Dr., Severn MD 21144 Mrs. Lynda Shawkey/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. Glen Haven Cemetery 6/17/2006 Glen Burnie, MD 4 Donation 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licer M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a COLUNI CARCINIUMA 1200NITTA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): physicien a s the burial-Division of Vital Records. P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown this certificate has been straight and director, page 2 should? Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 21X No 2 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNIE 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIS CAMP MIRMA AN, LINITHOUS, JA JOHN IMVIN 7.0 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 2 0 2006

		1	For State Registrer	State of Ma		epartme Certifica				giene () Reg. No.	06	19358
	4		1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ath Day	Year	3. Time of Death
	ysicia		John Lawrence	Gùyker, Sr.					June 2,		rear	2:00 AM
	Medic: camine		4a. Facility Name (If not institution, giv	e street and number)		4b. City	, Town, or	Location of Death	4c. County of Death			
	<i>3</i> 0.	1. A.	Prince Georges Hospit	al			F	Riverdale				Georges
/ Fun	neral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	Months	or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year) 131, 1935	9. Birthp Cour	place (State or Foreign
Dire	ctor		160-30-5290	EM 20 F	70	Yrs.			DECEMBER	31, 1935	5 P	Pennsylvania
pu &	1.625	<u></u>	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
faryli	No.	5	Maryland Princ	ce Georges			Rlac	densburg				1 ☑ Yes 2 ☐ No
ith the Marylan or 28a-f show	Settli	Director	10e. Street and Number	c debiges		10f. Z	ip Code	iensburg		10g. Citizen of	What Cour	ntry?
with	4			53rd Avenue,	ant #1			20710		United St	tatas s	of America
leath	TEN	Funeral	11. Marital Status	12. Was Decedent E		13. Was Dec	edent of H	spanic Origin? (Sp n, Mexican, Puerto			ce - Americ	can Indian,
fter	and:	듄	1 ☐ Never Married 2 🗷 Married	Armed Forces? 1 ☐ Yes 2 🛛 N	0				Hican, etc.)		ack, White,	
5-UU36 72 hours after death with the Maryland nature!, or Hema 23a or 28a-f show	the Medical Examiner motels be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 LA NO	Specify:		Speci	fy: HI	nite
72 hg	70	Completed	15. Decedent's E (Specify only highest gra	ducation	16a.	Decedent's Us		ation during most of work	ina	16b. Kind of 8	3usiness/In	dustry
	Mas	ם	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT	use retired)				
8 2 9	4	S		5+		Math Te	acher	18. Mother's Nam	n /Fires Adioballa	Maidan Cuma	Educat	ion
d be file	event,	Be	17. Father's Name (First, Middle, Last	, William Guyl	vor			15. Mother's Nam	, , , , , , , , , , , , , , , , , , , ,	Bobbin	me)	
YIS iould Mer	atic	၉	A Company of the Comp			Ctata Zir	Coda					
Man 12 st h and 7 te n	traur		19a. Informant's Name/Relationship (Tawnia Christensen, E					and Number or Rur e, Laurel, i			i, State, 2.1p	, Code)
C, I and I and Healt	ther	-	20a. Method of Disposition		20b. Place of	Disposition (N	ame of		Date	20c. Location	- City or To	own, State
IMORE, Maryland Pages 1 and 2 should be fi nent of Health and Mental H not: If Item 27 is marked of	0 0		1 ⊠ Burial 2 ☐ Cremation 3 ☐			y, cřematory`or ncoln Cem		1	9, 2006	R1 a done bu	ına Ma	bactva
Sattimore, bermit. Pages 1 ar Department of Hea	5	Ė	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fureral Service Lice		TOTC ET	22 Name	and Addres	s of Facility		Diadeliand	11 9 11a	il y land
Daitimo	ou o		Alan C	los Mr.		Fleck F	uneral	Home, Inc		Maryland	20707	
*		-	23a. Part1. Enter the disease, or com	plications that caused	the death. Do r						20,0,	Approximate
Dhuei	e or		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	iGNI	ant	0	41014	A	2000	Mila	Interval Between Onset and Death
Physi /Med			disease or condition resulting in death)	a	a consequence					1-711	7.114	
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ate be executed	e burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence	OI):						
n a c	E E	dlcai	•	d								
Records, P.O. Box 68 The law requires that the death certific	for use as	Physiclan/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					334 D	ate of delive	05/
BOX eath cert	forus	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetat death	3 ☐ Ectopic 5 ☐ Other (ate of delive lonth	Day Year
P.O.	ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	time or death	3 🗆 Cirier (specify					
That the	be detached f		Part tt. Dther significant conditions	contributing to death bu	ut not resulting in	n the underlying	cause giv	en in Part I.	23e. Did t	obacco use cor	tribute to t	he cause of death?
Division of Vital Records, or treatment of Vital Records, after death of Physician: The law requires to after death this certificate has been sinned in the confined to the pean sinned	d b	d by							1 🗆 '	Yes 2□No	3 🗌 Prot	oably 4,⊠Unknown
	should	Completed							24a. Was	an 24b.	. Were auto	psy findings available impletion of cause of
A s	1962	duic								rmed?	prior to co death? 1 \(\subseteq \text{ Yes}	
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of Vital Physician:	direct	To Be	examiner? 1 ☐ Yes 2 🕏 No	Hospital: 1 Anpatie	nt 2□ER/Ou	itpatient 3 🗆 l	Oth Oth	05	ome 5 Resi		her (Specif	٧)
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Visite of the stat	by th	Certification:	3 Suicide 6 Could not to determined		ury - At home, fa c. (Specify)	ırm, street, facto	ory, office		281. Location (. City or To		ber or Rura	al Route Number,
ital or	in bel	Cer										
DIV To the Hospital or A within 24 hours after	To the Fulled in by the funeral director, page completely filled in by the funeral director, page	edical	(Check only 2 Medicat Exe	hysicien: To the best o miner: On the basis of	examination an							
the hin 2	mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		9c. Licens	e number		29d. Date sign	ed (Month	Day, Year)
N N	9 8	-	255. Gigitature and title of certifiel				29c. License number 29d. Date signed (Month, Day, Year) June 19, 2006					
*				completed et	oath (Itam Car)	(Tupo Brian)	ر ک	000		Julie 13	, 2000	
10)		30. Name and address of person who		Greenway)rive	Greenbelt	. Marvlan	d 20770		
100 ES 22	Sta	te	Dr. Cecil Donald (31. Date filed (Month, Day, Year)				1110	di compo i c	, 1101 7 1011	5 20//0		
F	Registr		JUN 2 0 2006	32. Registra	15 Ap	role)			2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#13 16a 16b PERFF C856 6/20/06 WS
TTEM#19 of Maryland Department of Health and Mental Hygiene? 1 1 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 23:55^M Physician SARRETTSON -RANK 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Yrs. 85 Aug. 1,1920 212-16-3992 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ehow** rthan "natural", or items 23a or 28a-f ehovine Medical Examiner must be notified at 1 Yes XXNo MD Baltimore Owings Mills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Middlegate Court 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
XXYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married XXIII 2XXIII Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II Specify: δ XXWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) DATA PROCESSING MANAGER College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CO. GOVERNMENT Ith and Mental Hygie 27 ie markad other t r traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Unknown) Frank W. Garrettson, Sr. Genny 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Middlegate Court, Owings Mills, MD 21117 Itam 27 i Mark Garrettson / Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Fallston Methodist \$ = 5 XXBurial 2 Cremation 3 Removal from State Department of Important: If any Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 6/22/06 Fallston, MD Church Cemetery 21. Signature of Fdn M Service Lio 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Mu reco 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MENINGITIS wedes /Medical Due to (or as a consequence of): ANCOMYUN RESISTANT ENTEROCOCCUS INFECTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 KESECTION DOWER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificate funeral director. 25. Was case referred to medical 26. Place of Death | Check only one) Be examine Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 25(NO 2 ER/Outpatient 3 DOA ျှ 1 Tes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 Homicide ŏ To the Hospital within 24 hours a To the Funeral Completely filled The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and market as stated.

The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Kendall R Faullner MD 6601 N. Charles Street 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUN 2 0 2006

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3^{Day}2006 Month Physician 6:25am June 18 Charles L. Griffin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex Riverview Nursing Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July22,1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 **X**M 2 ☐ F Yrs. Maryland 216-16-8094 81 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 27 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 🛣 No Baltimore Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8130 Del Haven Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Iem 27 is marked other than "naturel", or Iter any injury or other traumatic event. The Mudle... 1X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Local 11 Asbestos Worker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Griffin Jeannett Kucera ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8130 Del HAven Road Baltimore MD Nora Hernandez 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Holly Hill Cemetery 6/22/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave. Balto.MD Connelly Funeral Home of Essex 21221 onn 23a. Part1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ueer nebruma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to for as a consequence of: P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. á 1 Yes 2 No 3 Probably 4 Chinknown Completed perteusive Asterioschafte Corner Oreslan 24b. Were autopsy lindings available prior to completion of cause of death? After this certificate has autopsy performed? ald cores our word an Accident 1 ☐ Yes 2 ☐ No 1 Yes 2 -NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No 4 Unursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph with n 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide (earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19667 Thereware turanous 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$ 508 Chen Boring, Hayland 21061 7310 Detclie Hylaco 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JUNE 16,2006 5:20A Kristine Marie Gascoyne /Medical 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F 004-58-7368 Director 54 June 22,1952 Michigan Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at by Funeral Director 1 XYes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3301 Glenmore Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 2 Maryland 21215-0036 1 ☐ Yes 2√√No Specify: 3 Widowed 4 Divorced 'natural' White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) 3rd. Grade Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Pages 1 and 2 should be Gloria Gascoyne Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health an Important: If Item 27 Is: any injury or other trau, Gloria Pellicot/Mother 3301 Glenmore Baltimore MD 21206 Avenue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/19/2006 Parkwood_Cemetery Baltimore 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc
6415 Belair Road Baltimore MD 21. Signature of Euneral Service Licensee 1 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a second Approximate interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** RECURRENT ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner RIGHT SIDED NECK MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use es the burial-transit DECUBITUS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ίο Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, SEVERE MENTAL RETARDATION funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MgUnknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an hes autopsy performed? certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 Yes 2 No Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how infury occurred After 1 Natural
2 Accident 5 Pending death. investigation 1 Yes 2 No the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospitel within 24 hours of Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 9 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) mella June D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar JUN 2 0 2006

State of Maryland / Department of Health and Mental Hygiene 9362 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 35 PM TIXEN BAUGH OHN 2000 19 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 10501 TAL 15ACTIM ORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) June 5,1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 15 M 2□F 77 216-22-5249 June Eckhart, MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at UXYes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21230 USA 1355 Hull Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Mayes 2 No And If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after cont of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or iter 1 ☐ Never Married 2 Marned White 1 Yes 2 No Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Telephone Co. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret L. Wampler George F. Hixenbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1355 Hull Street, Baltimore MD 21230 Dolores R. Hixenbaugh / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2- Semation 3 □ Removal from State permit. Page Depertment of Important: if ony injury or once. St. Stanislaus Cemetery Baltimore MD 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List bery one cause on each line. Approximate Interval Between one cause on each line. Onset and Death Immediate Cause (Final MONIA **Physician** 0 disease or condition resulting in death) /Medical 9 Examiner OCA x dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VASCUAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s hes autopsy performed? this certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation i Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier > 42634 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BALTROPE, MO 05M 51. OSEPH 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JUN 2 0 2006

State Registrar

JUNE 18, 2006

JOHN HARTMAN

		-	For State Registrar	State of M	laryland /	Departr Certifi				nd Me		iene	06	19364
			1. Decedent's Name (First, Middle, Last)						2	. Date of Dear Month	Dav	Year	3. Time of Death
	Physici /Medic	_	DONALD EDWARD	HOUGHTON		,					JUNE		2006	12:10pM
San San	Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number Medical	Cente	217				WSO			Balt	imore
West of the state	Funeral Director		213-20-3786	X 7. A	ige (In yrs. last I		Under 1 onths [Year Days	Hours	Min.	Date of Birth (Month, Day)	Year)	9. Birthp Cour Mary	
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location	on						1	0d. fnside City Limits
	Maryl f sho	ō	Maryland Baltimor	e County	B:	altimo	ro							1 ☐ Yes 2 🎇 No
	178e	Director	10e. Street and Number	e country	100		10f. Zip C	ode			1	0g. Citizen of V	/hat Cour	ntry?
	h with		7121 Heathfield	Road				21	1212				USA	
	deat	Funerai	11. Marital Status	12. Was Deceder Armed Forces		13. Was	Deceder	nt of His	panic Origi , Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race		an Indian, etc.
98	or its	Y.F.	1 Never Married 2 Married	1 Tes 25	No	1	Yes 2		Specify:			Specify		nite
8	72 hours after death with the Maryland "netural", or Itema 23a or 28e-f show cleaf Examinar must be nutified at	d by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates		ia. Decedent	e Heust (Occupat	tion		1	16b. Kind of Bu		
7	i within 72 ho ilene. r then "netur ine Medical	ojete	(Specify only highest grad	le completed)		(Give kind	d of work	done du	ırina most i	of working	7	700. 14.110 01 00	0111000111	20011)
212		Completed	Elementary/Secondary (0-12)	Colfege (1-4o	1	Master	Pla:	nner	-			Aeros	pace	Industry
þ	be filed ital Hygid of other	BeC	17. Father's Name (First, Middle, Last)						18. Mother	's Name (First, Middle,	Maiden Sumam	ө)	
/lar		10 E	Ralph Emory Houg	hton	_				Bes	ssie	Agnes	Walk	er	
Maryland 21215-0036	0 0 0		19a. Informant's Name/Relationship (T									r, City or Town,		
	- N -		Charlotte S. Houg	hton (W	ife)	7121 H	eath	fiel	ld Ros	id, B	altimo	re Mar 20c. Location -	y Land	1 21212
Ö	00		20a. Method of Disposition 1 Burial 2 Cremation 3		ceme	tery, cremato	ory or oth	er place)					
Baltimore,	permit. Pag Depertment important: i eny injury o		4 □Donation 5 □ Other (Specify, 21. Signation of Fun (Specify, 21. Signation of Fun (Specify, 22. Signation of Fun (Specify		Dura				of Facility		/22/200	o Timor	iium,	Maryland
Ba	Depermination of the permination		1 mount	1,000 201	1	Mi	tche	11 - W	Viedef	feld	Funera	1 Home,	Inc.	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each	ed the death. D				Road , , such as c	ardiac or	timore respiratory arr	, Mary La	and 2	Approximate Interval Between Onset and Death EDAYS
1	/Medical Examiner		disease or condition resulting in death)	Due to (or a	as a consequence	e of):	w/ F" F" 1	111					-	2 DAYS
		Jer	Sequentially list conditions, if any, leading to immediate	b	as a consequenc									
19	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· .	AC DYS		MIA							2 DAYS
Ö,	e exercian ar urial-t		resulting in death) Last	Due to (or a	as a consequenc	ce of):								
8760,	physic physic the bi	dica		d										
O. Box 6	ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death		topic prec ther (spec					23d. Dai Mo	e of deliventh	ery Day Year
P.0	res that the de signed by the e I be detached f		Part II. Other significant conditions co	ontributing to death	but not resultin	g in the unde	rlying cau	ise give	n in Part I.		23e. Did to	bacco use cont	ribute to ti	he cause of death?
Records,	puires n sign lid be	d by									1 🗆 Y	es 2 ∑ No	3 Prot	pably 4 Unknown
00	w requires been si	Completed									24a. Was a		Vere auto	psy findings available
Re	ician: The lav certificate has rector, page 2	E									autop perfor 1 Yes	med?	death?	mpletion of cause of 2 No
Vital	rtifica	0	25. Was case referred to medical						26. Place	of Death	(Check only or			
>	Physician: r this certific ral director.	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 🔀 Inpa	atient 2 ER/	Outpatient	3□ DOA		4 1107	sing Hom	e 5 Resid	ence 6 □Oth	er (Specil	(y)
n of	ding Physician: The In. After this certificate ha funeral director, page		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I	njury 28 Day Year)	b. Time of Injury		c. Injury Work			3d. Describe h	ow injury occuri	ed	
Division	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		′es 2□N		26 Langtion /C	troot and Numb	0. o. C.	I Coute Mumber
Ξ	or Att	in.	4 Homicide determined	286. Place of	Injury - At home etc. (Specify)	, farm, street,	, factory,	office		28	City or Tow		er or Hura	al Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Ce	25a Cortifier 1X Cortifying Ph	valcians To the he	et of my knowle	doe death in	omureid w	the tim	e data and	t place an	nd dual to than	ausu(s) and mi	neur as s	tatud
	24 hc Fun etely	dical	(Check only 2 Medical Examone)		of examination									
	To the within 2 To the comple	₹	29b. Signature and title of certifier					License	number			29d. Date signe	•	
			2 traute	WW. Se	no cal	, O.1	I	36	5663			Jon	6 18	,2006
	0		30. Name and address of person who	completed cause of	of death (Item 23	a) (Type, Pri	nt)							
	D		STUART R. WILL	ES, M.	76	01 OS	LER	DR:	ĮVE,	TOW	SON, I	MARYLA	ND 8	1204
	St Regis	ate	31. Date filed (Month, Day, Year)	S Reg	strar's Signature	Acort	e							

		•	For State Registrar	State of Ma	ryland / De	partmer ertificat	nt of H	ealth a Death	and Me	ental Hy	/giene		19	365
			Decedent's Name (First, Middle, Last)							2. Date of De	eath		3. Time of	Death
	Physici /Medio		Deborah G Ham	mand						Month	15 15	y Year	21:30	PM
	Examin	6	4a. Facility Name (If not institution, give st			4b. City,	Town, or	Location o	f Death		4c.	County of Deat	h	
		- 4	University of Maryland			150	Itim							
1	Funeral		5. Social Security Number 6. Sex	7. Age M 2 X) F	(In yrs. last birthd	Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	ay, Year)		hplace (State ountry)	
1	Director	}	222-46-3441 Usual Residence of Decedent		43				I	April	25,	1963 N	ew Jers	ey
	rland ow		10a. State 10b. County		10c. City, Town or	Location							10d. Inside C	ity Limits
	Mary	ţō	Maryland Harford		Bel Air								1 XYes	2□No
	h the	irec	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of What Co	untry?	
	th wit	by Funeral Director	9 Idlewild Court				210	14			1	USA		
	dea	ner		2. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Dece If Yes, spe			gin? (Spec	ify Yes or No		14. Race - Ame Black, White		
98	or It	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	1 ☐ Yes			, 1 00110 11			Specify:	s, etc.	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Madical Examiner must be invitted at	q p	3 Widowed 4 Divorced									W	nite	
5	n 72	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. De	cedent's Usu ive kind of wo e. DO NOT u	al Occupa ink done di	ition u <i>ring</i> most	of working	g	16b. K	ind of Business/	industry	
2	withii ene. then	mc	Elementary/Secondary (0-12)	College (1-4or 5-	+)						Dot	ail Foo	Corre	÷ 00
0	filed Hygi Sthar		17. Father's Name (First, Middle, Last)			'ood Se				(First, Middle			1 Serv.	ICE
an	ld be ental ked c	To Be	William (nmn)	Harri	son			Caro	ole A	nn Boi	rden			
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. M	ailing Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City o	r Town, State, 2	ip Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examiner must be writted at once.		Roger Hammond - Hu	sband	9 т	dlewil	d Cor	irt. I	Re1 A	ir. Ma	arvla	and 2101	Δ	
Te	of He of He itam		20a. Method of Disposition		20b. Place of Discemetery,	sposition (Nar	ne of ther place		Da	ite	20c. Lo	and 2101 ocation - City or	Town, State	
Baltimore,	Page nent c unt: If		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Darling				6/20/	2006	Darl	Lington,	Maryla	and
a	permit. Departr Imports any Inju		21. Signatural Funeral Service Licenses	/ /		22. Name ar					Fune	eral Hom	e, P.A	•
<u>m</u>	897 29		suffer al	luck		1317	Cokes	sbury	Road	l, Abir	ngdor	ı, Maryl	and 210	009
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each line	the death. Do not e.	enter the mod	le of dying	, such as o	cardiac or	respiratory a	ırrest,		Approximat Interval Bet	e ween
	Physician		tmmediate Cause (Final disease or condition	1)00	ischem	c C	rd:	N max	000	the			Onset and I	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		<u> </u>	CIVILY	0/03	1.0			/	
	Lamine		Sequentially list conditions, b.	Hypot	hyrord (3m							6 mon	ths
(Jo	si ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (br as a	consequence of):									
A.	be executed icien and burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):				•					
8760,	ate be executed hysicien and the burial-transit													
687		edicai	d .											
Вох	eath certific attending p for use as	Ž	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome o								23d. Date of deli	VADV.	
m	death e atte d for	Cia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at t		3 □Ectopic pr 5 □ Other (sp						Month		/ear
Ö	that the death cer ed by the attendir detached for use	hys	9 Unknown	9□ Unknown										_
Division of Vital Records, P.O.	Hospital or Attending Physician: The law requires that the death certific 44 hours after death. Funeral Director: After this certificate has been signed by the attending p felly filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contri	buting to death bu	t not resulting in the	underlying c	ause giver	n in Part I.		23e. Did t	tobacco u	se contribute to	the cause of d	eath?
ord	aw requirence is been single is should it	ed								10	Yes 2	ØNo 3□Pro	bably 4 □U	Inknown
ပ္ပ	e law r has be ge 2 sh	pie								24a. Was		24b. Were au	opsy findings a	available
<u> </u>	ysician: The lis certificate hadirector, page	Completed								perfo	rmed?	death?	2000	1036 01
/ita	iclan: Th	Be	25. Was case referred to medical examiner?					26. Place	of Death (Check only	one)			
of	Physi this c	၉	1 163 2 200	spital: Inpatien				4 🗆 (40)				3 □Other (Spec	ity)	
n	Jing I	lon	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur		8c. Injury			d. Describe	how injur	y occurred		
Si	death death tor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	28a Blace of Injur	At home form	M		es 2□N			Canada	44/	15	
ο̈́	after Direct In by	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, . (Specify)	street, ractory	, опісе		20	City or To	wn, State,	d Number or Ru)	al Houte Num	ber,
	spita iours neral filled		29a. Certifier 1 Certifying Physic	cian: To the best of	f my knowledge, de	ath occurred	at the time	date and	I place, an	d due to the	cause(s)	and manner as	hateta	
	e Ho	Medicai	(Check only 2 Medical Examine one)	er: On the basis of and manner stat	examination and/or	investigation	in my opi	nion, death	h occurred	at the time,	date and	place, and due	to the cause(s))
	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Director: Atter th completely filled in by the funeral	M	29b. Signature and title of certifier	/		290	. License	number	,		29d. Dat	e signed (Month	Day, Year)	
			1 Charles	an m.a.	Ph.D.	1	219	836			10	ne 15,	2006)
	()	-	30. Name and address of person who com	pleted cause of de	ath (Item 23a) (Typ	e. Print)								
_	D			25.6 re	enc St.,	130 Hi	mor	e, M	10	2120	1			
I.B.	Sta	-	31 Date filed (Month Day Year)	22 Distra	r's Signature	Part a								
	Registr	ar	JUN 2 0 200	D Brogod	w the	CORAL!	9							

	Physician
2	/Medical
3	Examiner
7	

Fune Direc

Physici /Media Examir

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt

Division of Vital Records, P.O. Box 68760,

174-18-2477 194 2 F 85 7/15 Mornins 1893 Flour's Min. Nov 6 1920 Pennsylvania			1 - For State Registrar		aryland / L			f Death	u Wellai h	Reg. No.	006	1936
South Security Number The American Control South Security South Security Number South Securi				,						Day		3. Time of Death
The street and Number 100. Country MD Baltimore 100. Color, from or Location 100. Secretary Annual Forest Number 100. Each 100. Secretary 100	mine ral		4a. Facility Name (If not institution, Franklin Square f 5. Social Security Number 6	give street and number) 1050 fa/Cen 3. Sex 7. Age		thờay) lf	ROSE Under 1 Ye	dale ar If Under 24	Hrs. 8. Date of 8 (Month, L	4c. Cour Book	1 / fir 9. Birth	nplace (State or Foreign
MD Baltimore Middle River 100 Street and Number 100 College 100 C	or		Usual Residence of Decedent						Nov	6 1920	Peni	
Twe signature Twe signatur		ctor		more								
Twe signature Twe signatur		al Ulre		ting Lane		10						untry?
Sample Supering		by Funer	1 Never Married 2 Married	Armed Forces? d 1 XYes 2 □ N If Yes, Give					(Specify Yes or Nuerto Rican, etc.)		lack, White	, etc.
Sample S		piered	(Specify only highest	grade completed)		Decedent's (Give kind life. DO N	S Usual Occ of work doi IOT use ret	supation ne during most of red)	working	16b. Kind of	Business/li	ndustry
Sample S		E .	12		Co	orrec	ction					Maryland
20a. Method of Disposition 1 Manuary 2 Chromation 3 Dearword from State 20b. Place of Disposition (Name of 20c) Chorder place) 21. Signaling of Puneral Service Licensee 22a. Part . Emer the disease. a conficilitions that caused the dealer from other the mode of drying, such as cardiac or respiratory arrest. 22a. Part . Emer the disease. a conficilitions that caused the dealer from other them mode of drying, such as cardiac or respiratory arrest. 22a. Part . Emer the disease. a conficient interval Between Consequence of the state of the cause (Final resulting in death) 22b. Place of Disposition (Name of 20c) 21 . Signaling of Puneral Service Licensee 22a. Part . Emer the disease. a conficient cause (Final resulting in death) 22b. Place of Disposition (Name of 20c) 22c. Location - City or Town, State 20c			Paul J. Haag					Ethe:	l Justi	ce	,	
1 Squaria 2 Cramation 3 Camelary, cremitatory or other places 4 Donation 5 D			19a. Informant's Name/Relationship Mildred B. Ha	ag Wife	3 ^{19b.}	Mailing Ad D 8 C	dress (Stre	etand Number of Sting 1	Rum/Route Num. Lane Ba	ber, City or Tow lto MD	n, State, Zi 212	ip Code) 2 0
21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Macce Ave Balto MD 23. Part I. Enter the disease, grammications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral Home of Essex Approximate inflavoral Between Outside and Death Connelly Inflavoral Funeral			1 XBurial 2 ☐ Cremation 3		cemeter	y, cremator	y or other p	· · · · · · · · · · · · · · · · · · ·				
23a. Part I. Enter the disease, g.confolications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval between cheek and beath disease or condition equiling in earth) Beginning in earth of the part 12 months? Beginning i	- SDC	Ì			1/	22. Nar	me and Add					
Sequentially list conditions, if any, leading to ammediate the final state of the control of the	ın		Immediate Cause (Final disease or condition	-a. Prec	moni	ot enter the	e mode of d	runera ying, such as card	al HOME	OI ES	sex	Approximate Interval Between Onset and Death
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	er	ian in car	that initiated events	b. Deme	ntia consequence o	rl):						Years
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	i look	alcal E	southing in oddin) East	d	consequence c	·f):						· · · · · · · · · · · · · · · · · · ·
25. Was case referred to medical examiner? 1			23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t	Fetal death			су				
25. Was case referred to medical examiner? 1	to he by	red by F	Part II. Other significant conditions Coronary Art	. \ .		the underly	ring cause o	iven in Part I.				
examiner? Continue	olumo	מוויסס	Stroke						- auto	ormea!	death?	
27. Manner of Death Natural Natu	α	וב	examiner?	Hospital:			0	-t				
29d. Date signed (Month, Day, Year)			27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	28b. Ti	me of jury	28c. Inj	ury at ork?				y)
29d. Date signed (Month, Day, Year)	Partific		datamia	286. Place of injur	ry - At home, fan (Specify)	m, street, fa	actory, office)	28f. Location (City or To	Street and Num wn, State)	ber or Rura	ti Route Number,
29d. Date signed (Month, Day, Year)	Jeoile	100	Chock only 2 Martical CX	enniner: On the pasis of e	examination and	death occur or investiga	rred at the ation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as si , and due to	fated. o the cause(s)
	Me		29b. Signature and title of certifier)					ч			

State Registrar 31. Date filed (Month, Day, Year)

Majid Cina, mo JUN 2 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8544 Wheatfield way, Ellicott City, MO 21043 32. Registrar's Signature

June 16, 2006

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Juhasz Day Month Year Physician 1,2abc+h 14:45 M Juna 2006 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimora If Under 1 Year If Under 24 Hrs. Hopkins The Johns Hospita 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 219-25-2838 20 Director 24, 1985 Maryland Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ad other than "natural", or items 23a or 28a-f show svent, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Prince George's Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7413 Varnum Street 20784 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mentel Hygiene. ant: if Item 27 is marked other than 3 +Student Towson University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Verona Saltzgaver Paul Alpar Juhasz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7413 Varnum Street, Landover Hills, MD 20784 Paul & Verona Juhasz – Parents 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
important: if its
any injury or of 1 ☐ Burial ∠ Cremation 3 ☐ Removal from State 4 ☐ Donation | 5 ☐ Other (Specify) Metropolitan Crematory 06/16/2006 Alexandria, Virginia 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition hypertension Physician pulmonary yeur /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed buriej-transit and Due to (or as a consequence of): P.O. Box 68760, ettending physicien Physician/Medica as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s certificete 2 No 1⊠Yes 2□No of Vital ners! Dirsctor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division Hospital or Attanding 1 Natural 5 Pending investigation death. 2 Accident within 24 hours after deal To the Funersi Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a Certifier 12 Certifying Physician: To the held of my knowledge, death occurred at the time, date and place, and due to the cauco(s) and manner as trafed. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 medical doctor RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Horkins Hopital, 600 North Wolfe Street, Maryland 21287 32. Registrars Signature Latif 31. Date filed (Month, Day, Year) State

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JUN 2 0 2006

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

OHNSON, LEAH

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	Dhuaia	:	1. Decedent's Name (First, Middle, L	ast)						2. Date of D Month		Day V		3. Time of Death
	Physic /Medi		Earl J. Jones							June :	16,	2006 Y	ar	9:35 P M
	Exami		4a. Facility Name (If not institution, ga	· ·		4b. City,	Town, or	Location of D	eath			4c. County of I	Death	
1	30 g		4204 Fifth Stree				k1yn	1				Baltim	ore	City
洗	Funeral Director		213-12-9591	Sex 7. Age (In y 1 ☑ M 2 ☐ F 86	rs. last birthday Yrs.) If Under Months	1 Year Days	Hours N	Hrs. Vin.	8. Date of B (Month, D Oct. 2	irth 21 ,	1919 M	Birthpl Count ary	ace (State or Foreign ry) Land
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation							10	d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	ector	Maryland Anne Ar		oklyn l	Park		<u> </u>						1 ☐ Yes 2 ☒ No
	with th	Dire	10e. Street and Number			10f. Zip					10g. (Citizen of Wha	t Coun	ry?
	ath v	rai	930 Hammonds Lan			212						ted St		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Importent: if Item 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic syent, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩		Was Deced If Yes, spec		spanic Origin' n, Mexican, Pi Specify:	? (Specuento R	ify Yes or N lican, etc.)	0-	14. Race - / Black, V Specify:	Vhite, e	n Indian, tc. ite
Ö	2 ho	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usua	Occupa	tion			16b.	Kind of Busin		
215	hin 7 Bn "n Medi	pie	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	rk done di se retired)	uring most of	working	g				
21	giene giene er tha	NO.	Elementary/Secondary (0-12)		Sheet	Meta	1 Me	chanic			Sh	eet Me	a1	Fabricatio
b	al Hy l oth		17. Father's Name (First, Middle, Las	t)				18. Mother's	Name	(First, Middle	e, Maid	en Sumame)		
<u> a</u>	uid b Vienti irked itlc s	To Be	John Jones					Carri	e Mo	oore				
Maryland	sho end I		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address	(Street a	nd Number o	r Rurai	Route Numb	oer, City	or Town, Sta	e, Zip	Code)
	and and in 27		Juanita Jones / 1	Niece	4204	Fifth	St.	, Broo	k1yı	n, Mar	y1a	nd 2122	25	
ore	of Horizon		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 (. Place of Dispe cemetery, cre	osition (Nam matory or ot	ne of ther place) T ₁	Da		20c.	Location - City	or Tov	vn, State
Ē	Pag ment ent: I		4 Denation & Other (Spec		edar Hi	11 Cen	neter	y	ne 200	21, 6	Bro	oklvn	Par	k, Marylan
Baltimore,	permit. Departimport import any inj		21. Signature of Fundal Service Lice	nsee	K 4	Name and irkle	d Address y-Rud ain]	ot Facility ddick			ome n B	, P.A. urnie,	MD	21061
\$3 gh			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de	ath. Do not en	ter the mode	of dying	, such as care	diac or	respiratory a	arrest,			Approximate Interval Between
J.	Physician		Immediate Cause (Final disease or condition	Luna	$C_{\mathcal{O}}$	$\Delta \Lambda$	00						1	Onset and Deal
	/Medical		resulting in death)	a. Due to (or as a cons	equence of):								+	~ mens q
	Examiner		Commentation line and state of											
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	icate be executed physicien and s the burial-transit	Examiner	that initiated events	c										
ó	exe en al	EX	resulting in death) Last	Due to (or as a cons	equence of):									
8760,	ite be iysici ne bu	icai		d										
9	ng ph	Jed	IE EENALE.											
Box	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pre Other (spe						23d. Date of Month		yay Year
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Records,	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying ca	use giver	n in Part I.						cause of death?
ec.	hesbe ge 2 sh	Completed								24a. Was		24b. Were	autops	y findings available
Œ.	The ste h page	mo:							_	auto perfo	psy ormed? 2 X N	death	?	oletion of cause of
Vital	striffic ctor,	Be C	25. Was case referred to medical examiner?					26. Place of D	Death (0 101	es 2	LI NO
of V	hysiclan: The la	10	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	it 3 DOA	Other					6 (2)Other (5)	necify)	Niece's Home
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury a	at				ury occurred	,,	Home
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Division	or Attan after deat Director; in by the	Certification:	3 Suicide 6 Could not be determined		home, farm, str	eet, factory,	office		28	f. Location (. City or Tox	Street a	and Number or	Rural I	Route Number,
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	To the Hospitel or Attanowithin 24 hours after death To the Funerel Director; completely filled in by the	Medical	29a. Certifier 1 🔀 Certifying Pl (Check only one) 1 Medical Exam	nysician: To the best of my ki miner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a vestigation, i	t the time in my opir	, date and pla nion, death oc	ace, and	d due to the at the time,	cause(date ar	s) and manner nd place, and c	as stat	ed. ne cause(s)
	To To a	Σ	29b. Signature and title of certifier	_ Nl.	1	29c.	License r	number			29d. D	ate signed (Mo	nth, Da	y, Year)
•	0		Konny	~ 100		D	390	41			Jun	e 19, 2	2006	
1.	1		30. Name and address of person who											
_	1		Ga Y atri Nimmagad				, Ba	1timor	e,]	Maryla	ind	21230		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 2006	32. Registrar's Sign										

Maryland 21215-0036

Baltimore,

law requires that the death certificate be executed

Records,

of Vital

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18 200 Far Grace E. Jenkins 2:25a M Jűne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 329 Riverside Drive Essex Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 4, 1928 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min 244-36-1108 77 Yrs. Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at MD Baltimore Essex Director 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With ō 329 Riverside Drive 21221 USA Iteme 23a death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after of Hygiene. other than "neturel", or Iter Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygient Important: If Item 27 Ie marked other that eny injury or other traumatic event, Insulance. own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lester Koonts Ada Athey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Neal /daughter 329 Riverside Drive Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 6/21/06 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death—ob not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Metastatic Ovarian Carcines gorceng disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760< Physician/Medical use as the attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec page 5 autopsy performed certificete 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physiclan: director 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Inpatient 1 Yes 2 ER/Outpatient 3 DOA this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Medical Certification: 1- Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 858 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) Illo Phludelphia Na (206) Batty Ma 21237 hudamu M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature heldon Milner, MD 31. Date filed (Month Pay, Xe State Registrar

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** June 5:20 A. Soon Hee Kim 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4315 Camellia Road Baltimore County Perry Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 13,1928 Non San, Korea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 F 77 Yrs 212-94-2130 Sept. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits worle itam 27 is marked other then "natural", or items 23a or 28e-f ebov other treumatic event, the Nedical Examinan must be multipled at 1 ☐ Yes 2 No Director Maryland Baltimore County Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4315 Camellia Road 21236 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: þ 3 ØWidowed 4 □ Divorced Korean Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. th and Mental Hyglene. 7 is marked other then "na Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 06 Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dal Park Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If itam 27 is m any injury or other treum once. 4315 Camellia Road Perry Hall, Maryland 21236 Mr. Chung K. Yi (Son In Law) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Gard. June 20,2006 Ellicott City, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GANGRENE Pnysician 6 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERIPHERAL Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): certificate be exec Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 212No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2⊠ No 1 Yes 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes __2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. To the ! To the 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 0035706 06, 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SATIAGITA HOSP. BALTO, NO 2/139 5601 LOCH RAVEN BLUS GHANDOUR 31. Date filed (Month, Day, Year)
JUN 2 0 2006 32. Registrar's Signature State Registrar

		-	For State Registrar	State of Maryla		partment of H Certificate of L			ene 200	6 19373
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		Margaret	Dolores		Kiernan		Month 06 I	Day Year 4 2000	
	/Medic		ta. Facility Name (If not institution, give st.				Location of Death		4c. County of De	
	Examin	er	201 Scotts Manor I						A == ==	A 1 - 1
			5. Social Security Number 6. Sex		rs. last birthd		en Burnie If Under 24 Hrs.	8. Date of Birth		e Arundel
	Funeral		1 🗆	M 2XE	V	Months Davs	Hours Min.	(Month, Day, Y	(ear) (irthplace (State or Foreign Country) MD
	Director	-	215-10-9930 Usual Residence of Decedent		2 ***			Nov 26,	1913	MD
	and and	ľ	10a. State 10b. County	10c.	City, Town o	r Location				10d. Inside City Limits
	fah.	5	MD Anne A	runde1		Clen	Burnie			1 ☐ Yes 2X No
	10 the 1	Director	10e. Street and Number	Tunder		10f. Zip Code	Durine	100	g. Citizen of What (Country?
	with	급		D			1061			5.A.
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28e-f ahow avant, the Medical Examinat must be notified at	Funeral	201 Scotts Manor	Drive 2. Was Decedent Ever in	us I			acify Yas or No-		nerican Indian.
	er de	un l	Tr. Marian States	Armed Forces?	0.5.	 Was Decedent of Hi If Yes, specify Cuba 	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
9	s aft	by F	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes XXNo	Specity:		Specify:	Vhite
3	hour		15. Decedent's Educa		16a De	ecedent's Usual Occupa	ation	16	Sb. Kind of Busines	
9500-61212	n 72	et	(Specify only highest grade	completed)	(G	ive kind of work done a le. DO NOT use retired	furing most of work	ing		
7	with:	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Superviso	r		US Indu	ictricc
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Maryland	Duid be f Mental I arked of atic ava	Be					Th	D417		
Ž	2 should be and Mental is marked c	၉	Charles Dalfonzo	- Original	105.14	ailing Address (Street a		a DiVence		Zin Code)
<u>a</u>	2 st 2 st 3 and 1 in n		19a. Informant's Name/Relationship (Type Mr. Kenneth Smith							
	s 1 and 2 should if Health and Men tam 27 is marke other traumatic			· · · · · · · · · · · · · · · · · · ·		740 10th St			Maryland Oc. Location - City o	
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Ε			4 □Donation 5 □ Other (Specify)	G1	en Hay	on Mem. Pa				nie, Maryland
Baltimore,	permit. Departrimports any inju		21. Signature of Funeral Service License			22. Name and Address	s of Facility	Singleto	n Funeral	Home, P.A.
<u> </u>	90F # 9		Mark ll Va	neura M	01357	1 Seco	nd Ave SW	, Glen	Burnie, N	ID 21061
			23a. Part1. Inter the disease, or complice shock, or heart failure. List only one	ations that caused the decause on each line.	eath. Do not	enter the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a cons	sequence of):	. ,	1-1	//		
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o,	exec on an ial-tr	Exa	resulting in death) Last	Due to (or as a cons	sequence of):	U				
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Box	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre		○ □□□			23d. Date of d	elivery
ň	The law requires that the death certifi sie has been signed by the attending l bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 (A) No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		3 ∐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
o.	that the de led by the a detached f	ys	9 Unknown	9□ Unknown						
٥.	es that igned b	<u>P</u>	Part II. Other significant conditions cont	ributing to death but not	resulting in th	e underlying cause give	en in Part I.	23e. Did toba	icco use contribute	to the cause of death?
g	w requires I been signe should be	d by	Chronie Obi	freque	hu	of fire	are	1X Yes	2 No 3	Probably 4 □Unknown
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ě	has ge 2	E	merily of his	14109 40	cocra	a) coolered		autopsy perform 1 \(\sum \) Yes 2	prior to	
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Ë	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:		otiont 30 DOA Othe	20	h (Check only one,		
5	Phys this al dir	၉	T Tes 21110	1 ☐ Inpatient 2	28b. Tim	atient 30 DOA	4 Iduising Ho	me 5 K.Residen 28d. Describe how	ce 6 Other (Sp	pecify)
2	Attanding Physicien: or death. actor: After this certifice by the funeral director, t	o	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year		ry Worl	(? Yes 2 □ No	200. Describe now	riquiy occurred	
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Division of Vital Records,	or At fter of pirac in by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)	, street, factory, office		City or Town,		Rural Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page				Lance 1 - 3	de alla e e e e e e e e e e e e e e e e e		and due to the	(a)	
	Hosp 4 hou Fune Bly fi	edicai	(Check only 2 Medical Exemin	ician: To the best of my er: On the basis of exam	knowledge, o iination and/o	meath occurred at the time or investigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner se and place, and d	as stated. ue to the cause(s)
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	wit Or Or	-	29b. Signature and title of certifier	\mathcal{D}	1	į.				
	_		Onlabour V	· falver	e3M	1000 Cm	78712	0	6-15-0	CUUD
	5		30. Name and address of person who cor	npleted cause of death (Item £3a) (Ty	(pe, Print) 1845	- Vatur	th Rd.	6 - 15-0 # 307 21061	
	<i>e)</i>		SHLVHELON U.	KAMIREZ	L H.	D Cole	1 BULINE	NO.	21061	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	1.0.				
	Regist	reli i	JUN 2 0 20	106 Sholies	A.G.	COBACL				

			State of M	•	epartment of F		ental Hygier	л 6 0 0 6	19374
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Death	Reg. I 2. Date of Death	No.	3. Time of Death
ı	Physici /Medic		(-ve	Lise	+5 (i			7th 2006	3.00 AM
2	Examin		4a. Facility Name (If not institution, give street and number)) 0	4b. City, Town, or	r Location of Death		4c. County of Death	
	1 100	. 3		sing Ler	ter		more	N/A	
	Funeral Director		488-03-4649 ¹□ ^M 2\ F	ge (In yı <mark>l</mark> s. last birth 88 Y	rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	1917 9. Birthol	ace (State or Foreign ry) inois
	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10	Od. Inside City Limits
	Mary -f she find a	tor	Maryland N/A	В	altimore				1 X Yes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Count	ry?
	ath wi		3320 Benson Avenue			21229		United St	
336	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show its Moulcal Exercites Lust Le notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Willing From 1 Yes, Give Year or Dates:	Ever in U.S. No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
5-0036	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	1 (Decedent's Usual Occup	during most of working	16b.	Kind of Business/Ind	ustry
2121	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other then "natural; other traumatic event, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4or 12 yrs.	5+)	life. DO NOT use retired Supply Deal		S-	tanley Hom	e Products
Maryland (d be filed antal Hygi ed other	Be	17. Father's Name (First, Middle, Last) Dmytro Sokalsky			18. Mother's Name Theodor	(First, Middle, Maid a Bakay	,	
ary	should be nd Mental marked c	P.	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	and Number or Rura			Code)
7.7	1 and 2 Health a em 27 is		Mrs. Mary T. Littlejohn / Daught		5109 Winste	ad Lane	Silver Spi	ring, Mary	land 20905
Baltimore,	permit. Pages 1 an Deportment of Heal Important: If item 2 any injury or other 2005.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name of c, crematory or other place hn Catholic	ce)		Location - City or Tov Drthampton	
Balti	permit. Deportra Imports any nju		21. Signature of Funeral Service Licenses Mi chael	E. Canapp	22. Name and Addre	ss of Facility J. Ruck,	T	Harford	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final	ine.		ng, such as cardiac of	Dui		Approximate Interval Between Onsel and Death
	Pnysician /Medical Examiner		disease or condition resulting in death) a	s a con ence of	f): / /			-	2 months
00 6	Examiner	e.	Sequentially list conditions b. Due to (or as	a consequence of	ment	a .		1	lears
	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Coro	nary a	rtery	dise a	is-e	y-ears
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Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me		e of pregnancy 2 Petal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of deliver Month	ry Day Year
, P.O.	that the	y Phy	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
rds	quires in sign uld be	d pa	Hypertension				1 ☐ Yes	2 □No 3 □ Proba	ably 4 Mnknown
Records,	'he law requir e has been si age 2 should l	Completed	Hyperlipidemia				24a. Was an autopsy performed	prior to com death?	osy findings available appletion of cause of
ital	iclan: The certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	10 103	
> \	Physic this ce al dire	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Inpat			4 Ninursing Hon		6 ☐Other (Specify)
ion	nding P ath. r: After t e funera	atlon:	27. Manner of Death 1 Matural 5 Pending (Month, Di	ury 28b. Ti a <i>y Year)</i> In	jury Wor	ryat rk? Yes 2 □No	28d. Describe how in	njury occurred	
Division of Vital	or Attendater death Director: , Jin by the f	Certification:		njury - Al home, far tc. <i>(Specify)</i>	m, street, factory, office	2	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospital or Attending Physiclen: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 10 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manners	of examination and	death occurred at the tire.	me, date and place, a opinion, death occurre	and due to the cause ad at the time, date	o(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1.	29c. Licens	se number	29d.	Date signed (Month, L	Jay, Year)
)	1			3/ ms	D	5539	1 Ju	une 174	4,2006
	4		30 Name and address of person who completed suse of Ming Vi 3320 Sen	death (Item 23a) (Type, Print) - Venue	Baltin	wre, N	lary lame	1 21227
Section 1	Sta Regist		31. Date (filed (Monu), Day, Year) 32 Regist	trar's Signature	Cools			/	

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death L. Decedent's Name (First, Middle, Last) Physician 12:50 AM UNE MELVILLE WARREN LOWMAN 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Chesapeake Arnold Anne Arundel H Under 1 Year If Under 24 Hrs. If Under 194 Hrs. If Under 194 Hrs. If Under 24 Hrs. If Under 24 Hrs. If Under 194 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 1925 218-18-0468 81 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 le marked other then "naturel", or Itema 23a or 28a-f ehow traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 K No Director Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 201 Winton Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after of al Hygiene. I other then "naturel", or Iter 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white Specify: 2 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Supervisor Shopping Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fill of Heelth and Mental H Be Clarence Lowman Julie Haywood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bonnie L. Nugent / daughter 796 Blenheim Court; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If Iter
any injury or oth June 26. 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem 2006 maral Jery 21. Signatu 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 1001120 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE END RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immudiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ned by the attending physicien and deteched for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 7 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 212 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending Parties death.

I Diractor: After it d in by the funera 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide A Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hoep within 24 hor To the Fune completely fi (Check only and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 157531 to completed cause of death (Item 23a) (Type, Print) 30. Name and address of person y Hwy Serete 204 860 Veterans 31. Date filed (Month, Day, Year) 32. Registrar's Fignatur State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 June 15, 3:00 a Julia S. Lorusso /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore St. Stephen's Green Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 31, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1. 1915 New York **Funeral** 1 ☐ M 2 💢 F 120-10-2738 Yrs 91 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "naturel", or Itams 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Timonium 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road 21093 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be Jennie Di Marzio Anthony Santoro ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. Kathleen Cornet / Daughter 13 Glenberry Court Phoenix, Md. 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06/21/06 4 ☐ Donation 5 ☐ Other (Specify) Holy Sepulchre Cem. New Rochelle, N. Y. 22. Name and Address of Facility 21. Signature of Funeral Survey Licenses 1050 York Road Ruck Towson Funeral Home, Inc. Towson, md. 21204 CE lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, we cause on each line. 23a. Part1. Enter the disease shock, or heart failure. se, or cont Approximate Interval Between Onset and Death Immediate Cause (Final to (or as a) on sequence of): Physician months disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed -transit and resulting in death) Last Due to (or as a consequence of): burial-Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year ö Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED LIVE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending 5 Pending investigation 1 Matural 1 Yes 2 No death. 2 Accident the Director: 6 Could not be 3 🗀 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after within 24 hours a To the Funeral C XC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (illem 23a) (Type, Print)
WH MD 2300 DU (avey 30. Name and address of person with Valley MD 2300 Pinestine 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink Oscar Diaz Lemus State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 17, 2006 Medical Examiner 0506 hrs Oscar A. Diaz Lemus 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Interstate 695 at Interstate 70 Security **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Director **X**XM 2 E^{Crunt}Salvador Yrs 215-61-4105 19 1986 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2XXNo 28a-f sho MD Baltimore Owings Mills death with the Maryland 10e. Street and Number 10g. Citizen of What Country notified at 靣 130 Embleton Rd. 21117 E1Salvador or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X X Never Married 2 Armed Forces White etc. Married XX No Yes If Yes, Give Year XX Yes 2 No specify:El Salvador White hours after Widowed Divorced Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nit Pages I and 2 should be filed within 72 Partment of Health and Mental Hygiene.
oortant: If item 27 is marked other than "r
iry or other traumatic event, the Medical E Baltimore, MD 21215-0036 12 Laborer Moving Company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Elmer C. Lemus Bertha A. Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer C. Lemus / Father 130 Embleton Rd. Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Evergreen
Memorial Park

| 22 Name and Address of Facility Eckhardt Funeral Chapel P.A. Donation 5 Other Specify Signature of Fareral Service |11605 Reisterstown Rd. Owings Mills,md211| 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): and 뗭 UNPENDED AMENDED physician the burial requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Physician/ Live birth 3 Ectopic pregnancy Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown been signed by the hould be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e Did tobacco use contribute to the cause of death? ģ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes ۵ 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Driver in MVA 1 Natural FOUND: 1 Yes 2 V No Pending Jun 17, 2006 0445 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Interstate 695 at Interstate 70, Security, Md. (Specify) Interstate/Express 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 17, 2006

State

Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner

Carol Allan, MD

31. Date filed (Month, Day Year)

		1	1 - State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department of Health / Department /	lental Hy	giene	06	19378
	D.	· 18	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day	Year	3. Time of Death
200	Physici /Medic		Gilbert H. Lawrence, Sr	Jun		2006	913PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Manland Medical Center Bultimore			y of Death	7-
(S	Funeral Director		5. Social Security Number 215-60-5784 6. Sex 1 Months 7. Age (In yrs. last birthday) 1 Yrs. 6. Sex 1 Months Days Hours Min.	8. Date of Bird (Month, Da June 7	y, Year)	Coun	lace (State or Foreign try) L
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mary First	to	MD N/A Baltimore				txXYes 2 ☐ No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Cour	try?
	23a c		409 Millington Ave. 21223		U.S.A.		
980	J within 72 hours after death with the Maryland jiene. I than "natural", or Itema 23a or 28e-f show I'ne Medical Exacilian ment be molified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No Rican, etc.)	Bla	ce - Americ ck, White, y: Whi	etc.
Maryland 21215-0036	within 72 ho iene. than "natur ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing	16b. Kind of 8		,
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ary.	d 2 should th and Men 7 is marke traumatic	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur		er, City or Town	, State, Zip	Code)
	12 4 7		Heather Klein/ Niece 3012 Highman Ave. Balt	imore M	21230		
Baltimore,	of h		20a. Method of Disposition 20b. Place of Disposition (Name of cemeracy, crematory or other place) 1 □ Burial 2★★ remation 3 □ Removal from State	Date 2-2006	20c. Location Odentor		wn, State
Balt	permit. Pag Department Important: I any injury o		21. Signatur of Funeral S. Vicalicenses 22. Name and Address of Facility Ambrose Funeral Horon	me, Inc.		2	27
K 35	Physician /Medical physician and physician a	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ot the	Tongo	e	8 months
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 1 1 1 1 1 1 1 1			ite of delive	ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A lichal whise	23e. Did to			e cause of death?
Il Records,		Completed		24a. Was autop perfor 1 Yes	rmed?	Were autop prior to con death? 1 \(\sum \text{Yes} \)	osy findings available inpletion of cause of 2 No
Vita	ician: certific rector,	Be	25. Was case referred to medicat examiner? Hospital: Other Other				
ō	Phys this ral du	lon: To	27. Manner of Death 1 Nursing Ho 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	ome 5 ☐ Resid 28d. Describe h)
Division	Hospital or Attending 4 hours after death. Funerel Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Numi vn. State)	per or Rura	Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the ored at the time, or	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the P within 24 To the F complete	Me	29b. Signature and title of certifier 29c. License number		29d. Date signe		
	4		Jonathan Jonker, MD P18587		Jun	07,0	2006
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Metric Review 22 5. Greene Street, Bultimo 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 0 2006	re, MD	2120		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 0 2006				

			1 - For State Registrar	State of Ma	ryland / D	epartme	nt of H	ealth ar	nd Mental F		e 2 n n s	10270
				41		Certifica	te of L	Jeath	O Data of	Reg. No	<u>,4000</u>	10012
	Physici	an	1. Decedent's Name (First, Middle, Las	~	-0				2. Date of Month	Da		3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	street and number)		4h Cih	Town or	Location of [N U C		6 2-006 c. County of Deal	
	Examir	ier	MCH, HAG	FR-STDO	ω \sim	1	ACI	ERST	MOWN		VASHI	/
-	Funeral		5. Social Security Number 6. Se		(In yrs. last birth		er 1 Year	If Under 24	Hrs. 8. Date of	Birth Day, Year		hplace (State or Foreign
	Director		218-86-8576 Number of December 1	DM 2□F	44 Y	rs. Months	Days	Hours		25	61	MD
	yland		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	a-f sl	ç	MD NA		Bal	timor	9					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Z	ip Code			10g. C	itizen of What Co	puntry?
	ath w		2500 East Madis					1205			U.S.A	
	iter de Items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin n, <mark>Me</mark> xican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
36	4 0 E	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	0	1 🗆 Yes	2 X ☐ No	Specify:			Specify:	Black
21215-0036	N BU		15. Decedent's Ed	ucation	16a. I	Decedent's Us	ual Occupa	ition		16b. H	Kind of Business/	
215		pie	(Specify only highest grad	College (1-4or 5		Give kind of w life. DO NOT	ork done d use retired,	fu <i>ring most</i> of	t working			
		Completed	12th grade	na		Barb	er				f-Empl	oyed
lnd		Be	17. Father's Name (First, Middle, Last)						Name (First, Midd			
<u> </u>	tould be I Mental narked c	2	James Miller						oris Ge			
Maryland	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationship (7 Monica Oliver-S						or Rural Route Num	. ,		re, Md 212
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	rscer	20b. Place of I	Disposition (Na	me of		Date	-	ocation - City or	
nor	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	, crematory`or			C /22 /0C			
Baltimore,			21. Sign fure of Funeral Service Licens						6/22/06	_ Ka	ndalis	town, Md
Ba	permit. Departr Importa any inji		I flyme t	+ Thomp	en	March 4300	F/H Waba:	West sh Av	e, Balt	imor	e, Md	21215
			23a. Part1. Enter the disease, or comp shock, enheart failure. List only of	lications that caused	the death. De se							Approximate
	Physician		Immediate Cause (Final disease or condition		PIRA	MRY		= A11	URE			Interval Between Onset and Death
	/Medical		resulting in death)	a	consequence of							
	Examiner		Sequentially list conditions	b. LIVI	ER	FAI	LV	RE				
,	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of							
	be executed ician and burial-transit	каш	that initiated events resulting in death) Last	c. AS	CITE	= 5_						
760,	be executed sician and burial-transit	cai E			consequence of							
687	<u> </u>		•	d								
Box (death certificat e attending phy d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of deli	verv
ă	death a atte	iciai	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth : 4□Pregnant at t		3 ☐Ectopic (Month	Day Year
o.	that the de ned by the a detached t	hys	9 Unknown	9□ Unknown								
۳,	The law requires that the tee by the bas been signed by the bage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in t	he underlying	cause give	n in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?
ğ	w requires t been signe should be	ed							1[Yes 2	XNo 3□Pro	obably 4 Dunknown
Records,	ne law requ nas been ge 2 shout	Completed							24a. W	as an topsy	24b. Were au	topsy findings available completion of cause of
œ —		Com								rformed?	death?	2 No
Vital	Phyaician: Th rthis certificate ral director, paç	Be (25. Was case referred to medical examiner?						Death (Check only			
of	Phyai this c al dire	은	THE ZY NO	Hospital: 1 X atier				4 Nursir	ng Home 5 ☐ Re			cify)
U C	ling F	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		ury	28c. Injury Work	?	28d. Describ	e how inju	ry occurred	
isio	Attanding r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	n/. At home fore	M . stract feats		'es 2 □ No	28f Location	/Etrant a	nd Mumber of De	ral Route Number.
Division	or Attand after death Director: / d in by the f	Certification:	4 Homicide determined	building, etc	(Specify)	1, 311991, 14010	y, onice		City or T	own, State	e)	rar noute Number,
_	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best o	f my knowledge,	death occurre	at the time	e, date and p	place, and due to the	e cause(s) and manner as	stated.
	To the P within 24 To the F complete	Medical	Oney	and manner star	ed.				occurred at the tim			
	Vit To CO	-	29b. Signature and title of certifier	MI			lc. License		~		ite signed (Month	* '
			()		/		06	338	3	70	NE 1	6 2006
	1		30. Name and address of person who c		ath (Item 23a) (T	ype, Print)	r.=4	CTT	141x 7 1.	10		b 2006
	Sta	te.	31. Date filed (Month, Day, Year)		r's Signature	_ U + //	41-1	>10				-
X	Registr		JUN 9 0 2	nns Ma	· M	Angel	27					

			1 - For State Registrar	State of Maryla			of Health a		Reg. No. CUL	6 19380
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Catherne 4a. Facility Name (If not institution, give s		۵	4b. City, Tov	m, or Location of	2. Date of I Month	Day You 200 4c. County of	Death
	Funeral Director		5. Social Security Number 214-22-4275 Usual Residence of Decedent		s. last birthday) Yrs.	If Under 1 Y	ear If Under 2 ays Hours			Birthplace (State or Foreign Country) est Virginia
	h the Maryland ir 28s-f show	Irector	10a. State 10b. County Maryland N/A 10e. Street and Number		oity, Town or Lo		de		10g. Citizen of Wha	10d. Inside City Limits 1
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-f show say injury or other traumatic avant, the Medical Examinar must be indiffied at ODDG.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	Apt 202 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		2123 Was Decedent f Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)		ates American Indian, White, etc. White
d 21215-0036	filed within 72 ho I Hygiene. other then "naturi ent, the Medical i	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last)	cation completed) College (1-4or 5+)	16a. Deced (Give life. Homen		one during most of tired)		16b. Kind of Busin Domesti	·
Maryland	2 should be i and Mental i is marked o aumatic svs	To Be	Robert Cecil McDon 19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (St	Floss	sie May Du		ite, Zip Code)
Baltimore, M	Pages 1 and 3 nent of Health ant: If item 27 ary or other tra		Willoughby Myrick, 20a. Method of Disposition Burial 2 Cremation 3 CRe 4 Donation 5 Other (Specify)	20b.	Place of Dispo cemetery, cren oly Rosa	sition (Name o	f place)	Date	20c. Location - Cit	
Balt	permit. Page Department of Important: if sny injury or once.		21. Signatury of Funeral Service License	ber CFS,	P 40	1 s. d		treet Bal	timore, Ma	eral Homes PA ryland 21231
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Finer Underlying	Due to (or as a conse	ant Ser	Riza	dying, such as c	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death Four House
,820,	death certificate be executed e ettending physicien and ad for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	equence of):					(4
P.O. Box 6	st the death certific by the ettending pi tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregr 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregna Other <i>(specif</i> y			23d. Date of Month	delivery Day Year
	requires the	ρ	Part II. Other significant conditions cont	Di Kak	sulting in the un	derlying cause	given in Part I.	_ 10]Yes 2 □ No 3 □	te lo the cause of death? Probably 4 Onknown
ıtal Ke	iicisn: The law certificete has I rector, page 2 s	Be Completed	25. Was case referred to medical examiner?				26. Place o	perl	opsy prior deat 2 No 1	e autopsy findings available to completion of cause of h? Yes 2 No
Division of Vital Records,	ending Physeath. or: After this the funeral di	Certification: To	1 Yes 2 No Ho 27. Manner of Death 1 Nordral 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. I	Other: 4 Nurs	28d. Describe	sidence 6 Other (5 how injury occurred	Бресіfy)
Ž	- 2		4 Homicide determined	28e. Place of Injury - At I building, etc. (Specician: To the best of my knar: On the basis of examinating and manager stated.	ify)	occurred at th	e time, date and	City or To	own, State)	r Rural Route Number, r as stated.
)	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	29b. Signature and title of certifier Adams 30. Name and address of person who com Johns Hyrms Bayu, 20	and manner stated.						
1	2		30. Name and address of person who com Johns Hypens Bayles	npleted cause of death (Ite	m 23a) (Type, F	Print) Easter	Avenue	Baltm	ve, Maryl	md 21224
1	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					

			1 - For State Ragistrar	State of Ma		epartment (Certificate	of Health and of Death	Mental Hy	/giene Reg. No	7000	19381
	Physici	an	1. Decedent's Name (First, Middle, L August	ast)	n	Povosko	2	2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g	ive street and number)			wn, or Location of Dea	June 1		. County of Dear	2:00am M
	Examir	iei	Greater Baltim		Center	Towso				altimor	
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	If Under 1			rth	9. Bin	thplace (State or Foreign
	Director		219-22-3293	1 ½ M 2□F	78 Y	rs.	Jays Hours Will	(Month. D	77	928 M	aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Many	to	MD Balt	imore	Bati	more					1 No 2 No
	th the	Director	10e. Street and Number			10f. Zip Ci			10g. Cit	tizen of What Co	ountry?
	deeth with the Maryland me 23s or 28s-1 show must be nutified at		5515 Walthe	r Ave.		2	21206			USA	
太	r de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deceder If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-	14. Race - Ame Black, Whit	
∑ % %	172 hours after deeth with the Marylan "natural", or iteme 23a or 28a-f ehow stical Examiner must be nuffited at	by Fi	1 ☐ Never Married 2XXMarried 3 ☐ Widowed 4 ☐ Divorced	MXYes 2 ☐ No If Yes, Give Year or Dates:	D	1 ☐ Yes 25	No Specify:			Specify: W	hite
28	2 hou	ed	15. Decedent's	Education	16a. E	Decedent's Usual (Occupation		16b. K	ind of Business	
£15	nin 72 na "na	piet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	- (Give kind of work of life. DO NOT use	done during most of wo retired)	orking		ited S	,
213	giene giene er the	Completed	12			rmy			Ar	med Fo	rces
OE	d oth	Be	17. Father's Name (First, Middle, Las	st)				me (First, Middle			
건 를	ould i	ပ္	John Morosko					nnie Lo			
S E	d 2 st th and 7 ts n traun		19a. Informant's Name/Relationship Jewel Morosk				treet and Number or R ther Ave				
, je	Healt Healt tam 2		20a. Method of Disposition	J - spouse	20b. Place of I	Disposition (Name	of	Date		ocation - City or	
	Pages nent of ant: If i		1 ☐ Burial 2/☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Gree	n Mount		ne 20, 006	Ва	ltimor	e, MD
Mor Og Baltimore, Ma	permit. Pages 1 and 2 should be filed within 77 Department of Health and Mental Hyglene. Important: if itam 27 is marked other than "ni eny injury or other traumatic event, the Mattle ODEs.		21. Signature of Fineral Service Lie	ensee		etery 22. Name and / Evans H	Address of Facility Funeral H			Harfor	d Rd. MD 21234
			23a. Part V. Enter the disease, or co shock, or heart failure. List on	mplications that caused to	the death. Do no						Approximate Interval Between
	Physician	87 3	Immediate Cause (Final disease or condition			ma.					Onset and Death
	/Medical Examiner		resulting in death)		consequence of						
	Examine	L	Sequentially list conditions,	b. Sef	1515						
1.6	led Islt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or w a	consequence of):					
(al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	·):					
68760,	ficate be executed physicien and s the burial-transli	edical		d.							
		ledi									
Вох	eath certifi ettending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		3 □Ectopic preg	nancy			23d. Date of del	,
E	ne death the ette hed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown		5 ☐ Other (speci				Month	Day Year
9.	that the de ed by the detached	/ Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying caus	se given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
Division of Vital Records, P.O.	sign d be	ed by					•				obably 4 Dunknown
ပိ	law requ as been 2 shouk	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of
= =	Physicien: The lithis certificete ha	Con						perfo	ormed? 2 ☑ No	death?	2□ No
Vite	ilcien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospitali			0	ath (Check only	0:		
of	Phys this al dir	10	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital:				Home 5 Resi			cify)
n	ding I h. After funer	tlon	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day		ury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	now injur	y occurred	
isi	l or Attendi after death. Director: A In by the fu	ficat	3 Suicide 6 Could not	be 290 Place of laive	v - At home, farr			28f. Location /	Street an	d Number or Ru	ral Route Number,
Ö	al or /	Certification:	4 Homicide determine	building, etc.	(Specify)	.,,		City or To	wn, State)	. La violato vidinos,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of aminer: On the basis of e	examination and	death occurred at for investigation, in	he time, date and place my opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Dat	te signed (Monti	n, Day, Year)
			1 Gintal	au mn	,	D	9059855		JA	ine i	9, 2006
	141		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ţ	ype, Privil)	Alin GAL		00	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
_	HJ		560/ Loca	1 Rower	1 11	id, I	39/timor	e, M	0-	2/293	3
1	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0	2006 32. Registrar	's Signature	war j					
			UNAU	4000 France.	2 18	Brack.					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 19382

		1- For State Registrar	Certific	eate of Death	riygione R	eg. No.	00 1330
Physicia Medical Exami		Decedent's Name (First, Middle,Last)			Date of Dea Month	th Day Year	3. Time of Death
Weuldai Exaiiii	ner	Stanley I. Onyenedum 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	June 14, 2	2006 4c. County of D	2203 hrs
		Franklin Square Hospital		Rosedale	sau i	Baltimore (
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last bir	thday) If Under 1 Year If Under 24	Hrs. 8. Date of Bir		. Birthplace (State or
Director		219-51-0073 1XM 2 F	24	Yrs. Months Days Hours	Min. 10/30)/1981 F	Country) Nigeria
λ.		Usual Residence of Decedent					
OW any			c. City, Town	or Location			10d Inside City Limits
Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number	Essex	10f. Zip Code	14	On Citimen of Miles	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	1100 Hartland Road Apt. I		21221	''	Og. Citizen of What Nigeria	Country?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once		11. Marital Status 12. Was Decedent Ev	er in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No	•	merican Indian, Black,
death or iten	Funeral	1 XNever Married 2 Married Armed Forces? 1 Yes 2	₹No	If Yes, specify Cuban, Mexican, Pur	erto Rican, etc.)	White, et	
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X No specify:		Specify.	Black
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done retired)	16b. Kind of Busine	ess/Industry
)36 hin 72 e than	Completed	12 College (1-4 b) 3+)		ursing Assistant		Healthca	ıra
5-0C ed wit fygien other	Co	17 Father's Name (First, Middle, Last)			me (First, Middle, N		-
21215-0036 ould be filed within 7 1 Mental Hygiene s marked other than it event, the Medica	B	Philip Onyenedum		Thessy	Adabogu		
○ 등 등 등 등	ပ္	19a Informant's Name/Relationship (Type, Print)		b. Mailing Address (Street and Number			
		Philip Onyenedum, Father 20a Method of Disposition	20b. Place o	504 Promentory Rid	ge Way, V	ista, CA	92081
F = 5 = 5		1 Burial 2 Cremation 3 X Removal from State	cremate	ory or other place)		Fairma O	y or Town, State Nigeria
트리의토토		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	St. M	ichael Church Cem. 22. Name and Address of Facility			suh, Imŏ State
Balti permit. Departi Importi		Misting X. Helton		22. Name and Address of Facility 5305 Harford Ro	Leonard J ad. Balti	. Ruck, I more. MD	nc. 21214
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	e death. Do no	ot enter the mode of dying, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. Drowning					Between Onset and Death
,		or condition resulting in death) Due to (or as a consequence of the condition resulting in death)	ence of):				
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	ence of):				
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	ongo of):				
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of the con	erice dr).				
	/Medical	X UNPENDED AMENDED item#	23a,27,2	28a-f,perME,G856,6/21/06	TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	/We	IF FEMALE: 23b. Was decedent pregnant in the	of pregnancy			23d. Date of deli	very
Box 687 The death certification is the attending of the astending of the sast the s	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at tim	e of death 5	Fetal death 3 Ectopic pre	gnancy	Month	Day Year
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S, P.C uires that n signed			<u> </u>		1 Yes	2 No 3 F	Probably 4 🗸 Unknown
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on C auth r: Af	ë	1 Natural 5 Pending (Month, Day, Year)		9:19 pm 1 Yes 2 X No			
Division ratending after death rate or al Director:	fica	2 A Accident investigation		irm, street, factory, office building, etc.			virming pool Rural Route Number, City
Division pipel or Attent ours after death eral Director:	Certification:	dotorminad	idence		Baltimore	_{ate)} 1225 Berl • MD	Rural Route Number, City Avenue
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only 1 Certifying Physician: To the best of my kr	nowledge, dea	ath occurred at the time, date and place, a	nd due to the cause	e(s) and manner as s	tarted.
To the comp	Medical	Medical Examiner: On the basis of examinaring and manner stated	ation and/or in		d at the time, date a		
	2	29b Signature and title of certifier		29c. License number		29d Date signed (
		30 Name and address of account who are it	h /ltor- 00	O.C.M.E.		June 15, 2006	
		 Name and address of person who completed cause of death Laron Locke MD. Assistant Medical Exam 		Penn Street, Baltimore, MD 2	201		
St	ate	31. Date filed (Month, Day, Year) 32. Egistrar's S		1			
Regist	rar	JUN 2 0 2006 Eleven	JF.	greete .			
DIMH TO Rev 1/20	TOC		OR	GINAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 6 **Physician** 19 Yvonne Pettus 2006 12:20p [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 1–15–30) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 232-36-8701 76 Director Trindad-Tobago Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel; or Items 23s or 28s-f ehow ury or other treumatic avent, the Medical Examinar must be recitled at 10d. Inside City Limits 1 Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 E. Eager Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 X Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Entertainer Cabaret 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Toussaint Phillip ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Toussaint Son P.O. Box 41201, Baltimore, Md. 21203 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If Ite any injury or ot 2005e. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 6-20-06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 + M March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER months 140 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physicien for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached ģ certificate has been signed rector, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier 1)25205 June 19, 2006 who completed cause of death (Item 23a) (Type, Print) N. Chales St. Palto Md 21203 6-Bmc 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 0 2006

Richard	Paul	Powers,	Sr.	
tionala	· uui	i owcis,	01.	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Physici		1. Decedent's Name (First, Middle,Last)	·		Date of Deat Month		3. Time of Death
dical Exami	ner	Richard Paul Powers, Sr. 4a Facility Name (if not institution, give street and number)		b. City, Town, or Location	June 15, 2	2006 4c. County of Dea	0000 hrs
		St. Joseph Hospital	- 4	Towson	or Death	Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7, Age (In yrs.	last birthday)		ler 24Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. E	Birthplace (State or
Director	L	218-38-3349 1 X M 2 F 65 Usual Residence of Decedent	Yrs.	Months Days Hour	March 2	27,1941 Fore	country) MD
any	ı		, Town or Location	on			10d. Inside City Limits
aryland 8a-f show at once.	ō		arkton				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number		10f. Zip Code	11	Og Citizen of What Co	untry?
ith the 23a or notifie		1229 Dairy Road 11. Marital Status 12. Was Decedent Ever in U	10 110 111	21120		USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No		Decedent of Hispanic Or es, specify Cuban, Mexican		- 14. Race - Ame White, etc.	erican Indian, Black,
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No specify	<i>r</i> :	Specify: Wh	ite
natur		15. Decedent's Education (Specify only highest grade completed)		's Usual Occupation (Give est of working life, DO NO		16b. Kind of Busines	s/Industry
36 hin 72 le. than "edical F	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)			. 455 . 5 547	Board of	
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natural c event, the Medical Examin	0 [17. Father's Name (First, Middle, Last)	Stepvan	n Driver	r's Name (First, Middle, N	Education	
1215. d be filed fental Hy sarked of event, th	Be C	James Paul Powers			ora Ford	raider (diffante)	
2121 ould be fi I Mental I marked ic event,	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Nu		nber, City or Town, Sta	te, Zip Cade)
MD d 2 sho lth and n 27 is numat		Betsy Powers/Wife			Parkton, MD	21120	
tra tea		20a Method of Disposition 20b. 1 X Burial 2 Cremation 3 Removal from State Pop		tion (Name of cemetery, er place)	June 22,	20c. Location - City of	or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: Met	hodist	Church Cem.	2006	Phoenix	
Baltimory permit. Pages I Department of I Important: If		21. Signature Frai Service Licensee Michael J. Fla	22. N. Lei	ame and Address of Facilingon Funeral W.: Padonia	Home of Du	laney Vall	ey, Inc.
Physician		23a Part I Enter the disease, or complications that caused the death	h. Do not enter th	e mode of dying, such as	cardiac or respiratory arre	um, MD 210	93 Approximate Interval
/Medical		failure. List only one cause on each line.					Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. ANESTRESIA CONDITION		typertensive at	HELOSCIETOLIC	Cartinovasciii	u disease
		Sequentially list conditions, b.					
	inel	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	of):				
- P	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	of):				
vecuted n and - transit	1 1	d.					
ਲਾਲ ਫ	Medical	▼ UNPENDED	a. 27 28a-f	nerME 0859 9/1	4/06 TT		
3760, ficate be g physici s the buri	J/Me	IF FEMALE: 23b. Was decedent pregnant in the	gnancy	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. 1/ 00 11	23d. Date of delive	·
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ord aw req as bee 2 shou	Completed				24a. Was autop	sy prior to	autopsy findings available i completion of cause of
Rec The la	팅				1 V Yes	med? death? 2 No 1	
Vital Reysician: The his certificate director, page	Be	25. Was case referred to medical examiner?			(Check only one)	<u> </u>	
FVII Physic r this	흔	1 ✓ Yes 2 No Tuspital 1 ✓ Inpatient 2	ER/Outpatient			Residence 6 Oth	er
Division of Vital Records, P.O. ral or Artending Physician: The law requires that the ras after death art interest. After this certificate has been signed by led in by the funeral director, page 2 should be detached in by the funeral director, page 2.	ü	27. Manner of Death 1 Natural 5 Pending 28a Date of Injury (Month, Day, Year)	28b. Time of Ir	· · · · _	_ 1	now injury occurred	
Sior Attend r death ector: by the	cati	2 X Accident Investigation June 6, 2006	unk	1 Yes 2 X	Campila	tions of anes	sthesia
Divi pital or ours afte eral Dir filled in	Certification:	determined (Specify) 1		t, ractory, office building, e	or Town, S	tate) St. Joseph	Rural Route Number, City I's Hospital
lospit 4 hour funer ely fill		29a Certifier		red at the time, date and n	Towson,		erted
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as!	Medical	one) 2 Medical Examiner: On the basis of examination :					
To Will	Me	29b. Signature and title of certifier		29c. License number	r	29d Date signed (M	onth, Day, Year)
, nl/		Paliffor Ali		O.C.M.E.		June 16, 2006	
1 OK		30. Name and address of person who completed cause of death (Iter	m 23a)				
Br	1	Zabiullah Ali, M.D. Assistant Medical Examine	r 111 Pen	n Street, Baltimore,	MD 21201		
	tate	47	ture for	N.			
Regis	trar	111N 2 0 2006 Beens	U. GOW				

		1	For State Registrar	State of M	i arylan	•			ealth a Death			giene Reg. No.	201)6	1938
			Decedent's Name (First, Middle, Las	1)				-			2. Date of De. Month	ath Day	Ye	ar	3. Time of Death
	Physicia		Gaudia Ro	se Perk	ins						June	15,			6:45pm _м
,	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location	of Death		4c.	County of C	eath	
-	LAGITIII	0.	Brinton Woods	Nursing	Home		S	ykesv	ille				Carro	11	
	Funeral		Social Security Number 6. S		ge (In yrs.	last birthday)	If Unde	Days	If Under Hours	24 Hrs.	8. Date of Bird (Month, Da	v. Year)		Birthpla	ace (State or Foreign
	Director		225-22-1627	□M 2□F	82	Yrs.	IVIOTITI	Days	110010		July 10	j, 19	23		Á
	9		Usual Residence of Decedent		100 Cit	Town only								10	d, Inside City Limits
	how		MD Baltin	ore	TOC. CIT	y, Town or Lo Balt:		ے						10	1 ☐ Yes 2X No
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	or 22	Director	10e. Street and Number				10f. Z	ip Code				10g. Citiz	zen of What	Count	ry?
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	te me	Funeral	11. Marital Status	12. Was Deceder Armed Forces	?	.S. 13.	Was Deci	ecify Cuba	ispanic Or n, Mexicai	igin? (Spe n, Puerto	cify Yes or No Rican, etc.))-	14. Race - A Black, V		
9	orl	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	Λ		1 🗆 Yes	2₽ No	Specify:				Specify:	Wh	ite
3	be lide within 72 hours after death with the Marylan Hygiene. At Hygiene. Ad other then "natural, or Itame 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Ed			16a. Dece	dent's Us	ual Occupa	ation	<u>-</u>		16b. Kir	nd of Busine	ess/Ind	ustry
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5	Hygic Hygic ont,	Ö	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden	Sumame)		
and	Aentat Aentat rked o	ToB	Connie Vivia	Reedy						Etti	e Lou I	Hende	rson		
	es 1 and 2 should be of Heelth and Mental filem 27 is marked or other treumatic ever	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Addre	ss (Street a	and Numb	er or Rura	I Route Numb	er, City or	Town, Sta	te, Zip	Code)
Ž	27 ts		Mrs. Lanna P. Whan	cton (Dau	ghter) 1691	Gem	ini D	rive	Syke	sville	, MD	21784	-	
ā,	Hee Hern othe		20a. Method of Disposition		1 1	Place of Dispo	sition (N	ame of	(A)	C	ate	20c. Lo	cation - City	or Tov	wn, State
	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			tle Wi				6/19	/2006	Mou	ith of	Wi	lson, VA
	permit. Page Department of Important: If ony injury of once.		21. Signature of Funeral Service Licen									GI E	DA (Be	v 1	05)
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ō	g Ph arth seral		27. Manner of Death	28a. Date of It	njury Day Year)	28b. Time o	of	28c. Injur Wor	y at		28d. Describe	how injur	y occurred		
0	Attending Physicien: r death. ector: Attar this certific by the funeral director.	atlo	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	1	,		М		Yes 2□	No .					
Divis	s efter des	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At h etc. (Speci	ome, farm, st	reet, facto	ory, office			28f. Location (City or To			r Rurai	Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours effecteath. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	ysician: To the be niner: On the basis and manner	of examina	owledge, dear ation and/or in	th occurre ivestigation	ed at the tir	me, date a pinion, de	nd place, ath occuri	and due to the red at the time,	date and	place, and	due to	the cause(s)
	within 2 To the I	Σ	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Dat	e signed (A	lonth, L	Day, Year)
			1/1/1/ U	11. IN	10			000	581	37		6	1661	6	
	N		30. Name and address of person who	completed cause of	f death (Ite	m 23a) (Type	, Print)				, ,		-		
_	8		Wille la	295	Ston	e Av	e St	30	2 /	Ust	mins fe	//	UD.	211	57
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regi	strar's Sign	ature	1	-							

State of Maryland / Department of Health and Mental Hygiene-1 - For Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Agnes T. Quick JUNE 5:55PM 16 /Medical 2.006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9000 HOSPITAL BALTIMORE SAMARITAN n/a If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day,) 3/8/23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Director 218-12-7171 83 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28e-f show other treumatic event, the Madical Exactinar must be notified at 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3138 Elliott Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2**%** No fYes, Give 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3.XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Anthony Malinoski Teresa Lisek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bernadette Vece 3124 Elliott St. Baltimore, Md. 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
eny Injury or ot Sacred of Hear the of Deep Jesus Cemetery 1. Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/06 Dundalk, Md. 21. Signature of Funeral Service la KaczorowskifacFuneral Home P. A. 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24a. Was an this certificate has autopsy performed 1 Yes .2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the more after death, within 24 hours after death.

To the Funerel Director: After the function of the func 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 JUNE 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APOORU BROCK, GOOD STATMARITION HOSPITAL, 5601 LOCH RAVEN BLVD

BRETIMORE MD - 212 39 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

96NOFS

			For State Ragistrar	State of M	arylan	d / Depa <i>Cei</i>	artment of rtificate of	Health a f Death	ind Me		jiene	06	19387
	Physici	25	1. Decedent's Name (First, Middle, La	est)						2. Date of Dea Month		Year	3. Time of Death
	/Medic		Jean R	ice					_	June	14	2006	1:15 AM
*	Examin	er	4a. Facility Name (If not institution, give Harbor Hospital	e street and number)			Baltimo		Death			ity of Death	
-	- Funeral		Social Security Number 6. 5	_	e (In yrs.	last birthday)	If Under 1 Yea	r If Under 2	24 Hrs.	8. Date of Birth (Month, Day		VA 9. Birthp	lace (State or Foreign
	Director		210-42-0227	1 □ M 2 💢 F	63	Yrs.	Months Day	s Hours	Min.	12-17	7–42	Cour	Md.
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary	tor	Md. NA			Balti	more						X □Yes 2□No
	or 284	Oirec	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Cour	ntry?
	s 23s	rai	701 Arlington Av	-	604		212					JSA	
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or items 23e or 28e-f ehow implies event, the Madical Exemples main to notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cu I ☐ Yes 2X N	iban, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		ace - Americ ack, White, ify: Bla	etc.
21215-0036	72 ho	Completed	15. Decedent's E			16a. Deced	ient's Usual Occ kind of work don	upation e during most	of working	2	16b. Kind of	Business/Inc	dustry
121	within ne. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. I	DO NOT use reti	red)		•		_	
	Hygi Hygi other		10th grade 17. Father's Name (First, Middle, Last)		PI	ece Wor		's Name ((First, Middle, i	Londo Maiden Suma		
<u>Ian</u>	should be nd Mental marked o	To Be	Cliford		Hug	hes		I	nez		R	ice	
Maryland	2 6 8 3	·	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address (Stree	et and Number	or Rural	Route Number	. City or Town	n, State, Zip	Code)
<u>o</u>	1 and 2 Health tem 27		Sharon Cosby 20a. Method of Disposition	Daughter	20b. P	lace of Disno	5 Centre	1	, Ba		, Md. 20c. Location	21224	
פֿר	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	C	emetery, crem t. Zio	natory or other p		6–22-			owne /	
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licer		2	22	Name and Add	ress of Facility			imore,	Md.	21202
ý.	a - 1		23a. Part1. Enter the disease, or com	plications that caused	the death							n Ave.	Approximate
e se	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	SOAS		20 40	cecal	Dor	la	ation			Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit	dical		d							-		
Box 6	death certifii e attending p id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnan	су				ate of delive	ry Day Year
о. О.	0 0 0	Physician/M	1 □ Yes 2 2 100 9 □ Unknown	4 Pregnant at 9 Unknown			Other (specify)						
	law requires that the as been signed by th 2 should be detache	Ď	Part II. Other significant conditions of	contributing to death b	ut not resu	ulting in the ur	nderlying cause g	Iven in Part I.			acco use cor es 2 □ No		e cause of death?
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	within 24 h	Medical	(Check only 2 Medical Exar	ninar: On the basis of and manner sta	examinat	lion and/or inv	estigation, in my	opinion, death	occurred	at the time, da	ate and place	, and due to	the cause(s)
	To T Com	Σ	29b. Signature and title of certifier				29c. Licer	nse number	1	-	d. Date sign		
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	7		30. Name and address of person who Bassel Alk Walil, Har 31. Date filed (Month, Day, Year)	rbor Hospit	7/3	00/50	ith Hanor	nerst. a	3alti	more,	MD, :	21225	•
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			State of Maryland / Department of Health and Me	ental Hygien	e ₂ n n 6	10388
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	/Medic Examin	- 37	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death	1
			6401 Loch Raven Blvd. Apt. 216 Baltimore 5 Social Sequitive Number 16 Sex 17 App. (In vis. last hirthday) If Under 1 Year If Under 24 Hrs.	D. Data of Birth	N/A	The second secon
. B	Funeral Director		Months Days Hours Min.	8. Date of Birth (Month, Day, Year Sept. 29,		nplace (State or Foreign untry) aryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	,		10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "netural", or iteme 23s or 28s-f show event, the Mau ral Exeminer must be notified at	5				1 XYes 2 No
	the r	Funeral Director	Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code	10g. C	itizen of What Co	untry?
	h with	a D	6401 Loch Raven Blvd. Apt. 216 21239		United	States
	eme 2	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Forces)	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 □ Never Married 2 □ Married 1 X□ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates: WWII		Specify:	White
8	ture!	edt	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/l	Industry
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Maryland 21215-0036	lid be fill fental H rked oth	Be C		Alberta		
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	1 and 2 : Heelth ar iom 27 is		Mrs. Ruth Amy Hiner - Daughter 10 Walnut Point Lane	Ocean Vie	w. Delaw	are 19970
ore,	es 1 a of He of He r other	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or	
ij	Pages ment of tant: If It lury or o		4 Donation 5 Other (Specify) Gardens of Falth Celli. U0/2		Baltimore D5 Harfor	, Maryland
Baltimore,	permit. Pages Department of i Important: If It eny Injury or o once.		21. Signature of Funeral Bayros Licensee Michael E. Canapp 22. Name and Address of Facility Leonard J. Ruck,			MD 21214
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	10+1		30. Name and address of person who completed gause of death (Item 23a) (Type, Print). Again the Mills (MD) Coroll Lamenta Hospital. 560/ Lock/	Caren Bed	By Hay and	412020
	t l L® St	ate	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	de la company	Cirmen	7
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<i>*</i>		1 h auster	Darle us		0	23809		June	14, 2006
L. Austra Doyle ms, Greenelsourn Caucer Ctr., 22 S. Creere St., Boltwore, Ma 21201 State 31. Date filed (Month, Day, Year) 32 (Registrar's Signature -		3									
State 31. Date filed (Month, Day, Year) 32 (Registrar's Signature		== ====================================			us, Greenelou	um C	aucer Ch	-, 22	S. Crezzo	St., Balti	more, Ma 21201
Registrar JUN 2 0 2000 Communication of the state of the			_	31. Date filed (Month, Day, Year) JUN 2 0 21	32 Registrar's Signa	ature	anti)				

			For State Registrar	State of Ma	ıryland / [Departme Certifica	ent of Health ate of Death	and Me		giene Reg. No.	2006	19390
			1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ath		3. Time of Death
	ysicia Aedic	_	Andrew Si	nith				-	JUNE	188	2000	0656 AM
	amin		4a. Facility Name (If not institution, giv	e street and number)		_	ty, Town, or Location				County of Death	
			University of M	layland H	ospital	13	altimore			Bo	11timore	S CITY
Fun	eral		Social Security Number 6. S	ex 7. Age	(In yrs. last bir	Mont		r 24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)	9. Birth Cou	place (State or Foreign intry)
Dire	ctor		219-52-8885 Usual Residence of Decedent	A 201	55	Yrs.			11 0	6 5	50	MD
and			10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
ith the Marylar or 28a-f show	8 2	5	MD NA		Balt	imore						1 Tyyes 2 □ No
the t	1	Director	10e. Street and Number		Durc		Zip Code			10g. Citiz	en of What Cou	intry?
with 3s or	3		4501 Delesion 2				07075			17	77 0 1	
death Te 2		Funerai	4521 Belvieu A 11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	21215 cedent of Hispanic Or	rigin? (Spec	cify Yes or No	. 1	U.S. A 4. Race - Ameri	ican Indian,
or its	를	Ī	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0		pecify Cuban, Mexica 2X No Specify		rican, etc.)		Black, White	
If I I I I I I I I I I I I I I I I I I	2	D D	3 XWidowed 4 ☐ Divorced	Year or Dates:		10 10:	ZALINO Specily	/· 			Specify: E	Black
72 h	la la	Completed	15. Decedent's En (Specify only highest gra	ducation ide completed)	16a.	(Give kind of	sual Occupation work done during mos	st of workin	ng	16b. Kin	d of Business/li	ndustry
Athin han	8	<u>d</u>	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO						
lled v tygie	를		10th grade 17. Father's Name (First, Middle, Last,	na		Roc	fer 18 Moth	ner's Name	(First, Middle,	Roof	ing (Contractor
t be fi	BVB:	Be									ourname)	
2 should be filed withing and Mental Hygiene.	Tati	ဥ	Robert Lee Smi 19a. Informant's Name/Relationship (196	Mailing Addr	EQ1T ess (Street and Numb		rring		Town State 7	n Code)
d2s d2s than than	other traumatic avent, the Medical Examinar must be muitified at		Stella Smith-S			•	,				,	,
1 and 2 Health	the		20a. Method of Disposition	rscer	20b. Place of	DEL DE f Disposition (i ry, crematory	lieu Ave	Ba Da	IE1mo	20c. Loc	ation - City or T	215 own, State
ages of First	y or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		i		,	- (1)	2/06			
permit. Pages 1 and 2 Department of Health 8 Important: If Item 27 is	in ju	}	21. Signature of Funeral Service Lices		KING	22. Name	ial Park	1ity	3/06	kand	alisto	wa Md
Deg m	any is		Colline A	Thompson	ت_		and Address of Facil		D = 1 + .			01015
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do	not enter the n	Wabash node of dying, such as	s cardiac or	respiratory ar	rest,	e, Ma	21215 Approximate
Pnysic	rian i		shock or heart failure. List only Immediate Cause (Final		fails	50					d	Interval Between Onset and Death
/Med	_		disease or condition resulting in death)	w	consequence						_	
Exam	iner		On a self-th disk as self-th	Liver	CIT	chosi	Š					
17		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence	of):						
ocute.	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·	1+1+15							
be executed icien and	urial	ũ	resulting in death) cast	Due to (or as a	a consequence	of):						
o / o cate t	the burial-transit	dicai	•	d								
The law requires that the death certific ste has been signed by the attending p	should be detached for use as	Physician/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy							
atten	for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 □ Fetal death	3 □Ectopii 5 □ Other	pregnancy			23	3d. Date of deliv Month	ery Day Year
is the contract of	ched	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	timo or death	3 0 0 0 0 0 0	(specify)		•			
that hed by	deta		Part II. Other significant conditions of	contributing to death bu	it not resulting in	n the underlyin	g cause given in Part	I.	23e. Did to	bacco us	e contribute to	the cause of death?
orus requires een sigr	ld be	d by							1 🗆 Y	es 2	No 3□Pro	bably 4 Unknown
S ™ red		iete							24a. Was	an	24b. Were auto	opsy findings available
he las	page 2	Completed							autop	med?	prior to co death?	empletion of cause of
	tor, p	0	25. Was case referred to medical				26 Plac	e of Death	(Check only o	20 No	1 🗆 Yes	21 No
yeici	direc	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Appatie	nt 2□ER/Ou	itpatient 3	Othor				☐Other (Speci	fv)
2 E 5	Jerai		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of njury	28c. Injury at Work?		8d. Describe h			
ath. A	he fu	atic	2 Accident investigatio	n		M	1 ☐ Yes 2 ☐]No				
ratt rede	by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, fa	ırm, street, fac	tory, office	2	8f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,
rai D	lled ir											
DIVISION OF VICE To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Atter this certified	completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination an	e, death occur id/or investigat	ed at the time, date a ion, in my opinion, de	ind place, a ath occurre	nd due to the o d at the time, o	ause(s) a date and p	and manner as solace, and due t	stated. o the cause(s)
o the	ldwo	Me	29b. Signature and title of certifier	()			29c. License number			29d. Date	signed (Month,	Day, Year)
->-	,		+ Y- Joh	1 M June)		P19825	5		Jun	181 91	2006
	\		30. Name and address of person who									5.00
(5		Eric Schwartz		Green	e stre	set, Balt	rimore	OM,	2120	10	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Bras	24.1.					
Re	egistr	ar	JUN 2.0	2006	me &	Lores	E.					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 16, 2006 3:50 P. Karen Lee Stallard June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore County 505 Overbrook Road Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** Months Days 1 ☐ M 2 🔀 F 21,1947 58 Baltimore, MD. 212-52-9493 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or Items 23a or 28a-f show Examinational be notified at 1 ☐ Yes 2 X No Maryland Baltimore County Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 United States 505 Overbrook Road Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Henry Adams Consult. than the Me College (1-4or 5+) Elementary/Secondary (0-12) Engineering Book Keeper 12 03 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental H Importent: If Item 27 is marked oth any injury or other traumatic even 2006. Be Ralph D. Finkbinder Dorothea Beryl Dinker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John W. Stallard (Husband) 505 Overbrook Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery June 19,2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death near Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 1 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed 1 Yes 2 🖺 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 1 Tyes 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural М 1 Yes 2 No after death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES STREET NORTH CHARL 31. Date filed (Month, Day, Year) JUN 2 0 2006 32. Pagistrar's Signature State Registrar

ORIGINAL

		1 - For State Registrar		Sta	ate of	магуіа	nd / Dep <i>Ce</i>			ieaith a Death	ina M		Reg. No.	006	19392
Dhuciai	ion	1. Decedent's Name	e (First, Middl	e, Last)								2. Date of De Month	ath Day	Year	3. Time of Death
Physici /Medi		Anne					Szcz	esnia	k			June_	15,	2006	12:00P ^M
Examir	ner	4a. Facility Name (II		-	and numb	er)				Location of	f Death		4c. Co	unty of Death	
		413 Blair				4 //-			ern	I II Hadas S	a Mea T			e Arun	
Funeral		5. Social Security N 266-65-75		6. Sex 1 ☐ M :	2 ⊠ F		s. last birthday) 7 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Nov . 16	th ly, Year)		place (State or Foreign intry)
Director		Usual Residence of				5	/ 113.				i	Nov.16	,1948	Scot	land
and w		10a. State	10b. County			10c. 0	City, Town or Lo	ocation							10d. Inside City Limits
Mary	ō	MD	Anne A	runde]		Se	vern								1 ☐ Yes 2√☐ No
28a	Director	10e. Street and Nur	mber					10f. Zip	Code				10g. Citizen	of What Cou	intry?
3a o	0	413 Blair	field	Court				211	1.1.				USA		
me 2	Funeral	11. Marital Status	TICIU	12. W	as Decede	ent Ever in	U.S. 13.	Was Dece	dent of Hi	ispanic Orig	in? (Spe	cify Yes or No	14.	Race - Amen	
or ite	F	1 Never Marri	ied 2□ Mar	ried 1	☐ Yes 2 Yes, Give	ON CA		ıı res, sper 1 ☐ Yes	-	n, Mexican, Specify:	, Puello	nicari, etc.)	Ca	Black, White, ecity: Whi	
Per.	1 by	3XXWidowed	4 Divorced	i Ÿ	ear or Date	es:		103	2122140	оросну.			36	ecny. WIII	
72 h natu	Completed	(Spec	15. Deceder	nt's Education			(Give	dent's Usu	rk done d	during most	of worki	ng	16b. Kind	of Business/In	ndustry
dthin ne.	Idm	Elementary/Seco		С	ollege (1-4	or 5+)		DO NOT u		•					
led v lygie her t		17. Father's Name	12	(act)		·	Comp	uter	Anal		r'e Nama	(First, Middle	Reta		
be fi	Be	George B		Lasi)								•	, WIZIGEN SU	maine)	
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Imarked other than "naturel", or iteme 23e or 28e-f show unarked other than "naturel", and item provided at unafter must be positived at	2	19a. Informant's Na		ship (Tung D	nine)		10b Maili	na Addras	/Strant			derson	as City as To	um Ctata 7i	- Code)
12 st h and 7 ie r treur															b Code)
1 and Healt Healt Healt ther		Joanne L 20a. Method of Diss		ger/da	ugnte		Place of Dispo	sition (Na/	ne of		rt;	Severn,	MD 2 20c. Locati	1144 ion - City or To	own. State
in in in in in in in in in in in in in i		1 🗆 Burial 2	Cremation		al from St	ate	cemetery, cre	matory or c	ther plac		June	18,			
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mentai Hygiene. Important: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be published at once.		4 ☐ Donation 21. Signatu → 0	-//			Che	esapeak	e Cre	m. C	enter		006		nsvill	
Depa Impo eny ir		DI SIGNALUT	The Control of the Co	Liconsoo	-	241						D			Ave. SW
		23a. Part1. Enter t	ne disease o	r complication	ns that cau									en Buri	nie, MD 210
		shock, or hea	rt failure. List	only one car	use on eac	h line.	A				0210100	n roophatory a			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a	-	un	9	an	Cer	\					4 Months
Examiner		,			Due to (or	as a cons	nce of):								1
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ted nsit	를	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rtying -	<	(1)		,								
xecu and al-tra	Examin	that initiated events resulting in death) I	s Last	c	Due to (or	as a conse	equence of):								
icate be executed physician and s the burial-transit	dical														
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ician: The law requires that the death certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent	t pregnant			me of preg							23d	. Date of deliv	ery
death a atte	Cia	in the past 12 1 ☐ Yes 2 0	months?	4	Pregnan	h 2∏Fe ntattime of		JEctopic pi ∃Other (sp						Month	Day Year
the oy the	ys	9 Unknown		9	Unknow	m									
s thet ned b	by P	Part II. Other signif	ficant conditi	ons contribu	ting to dea	th but not re	esulting in the u	nderlying o	ause givi	en in Part I.		23e. Did t	obacco use	contribute to t	the cause of death?
ruires n sig												1700	Yes 2□N	lo 3 Prot	bably 4 □Unknown
w rec bee	Completed											24a. Was	an 2	4b. Were auto	opsy findings available
he ia e hes ige 2	E G										_	autoj perfo	osy ormed?	prior to co death?	empletion of cause of
n: Ti ficeto or, pa	ပို	25. Was case refer	rod to modica	1 - 6						00 81	-1 0 11	1 Yes	2 X No	1 🗆 Yes	2 □ No
sicia cert	o B	examiner?		Hospit	al: 1 🗆 Inp	nationt 3	☐ ER/Outpatie	nt 3 D0	Othe	00		Check only o		Other (See	4.1
Phy r this		27. Manner of Deat		28	a. Date of	Injury	28b. Time o		Bc. Injun Worl	4 🗆 19 01		me 5 Resi 28d. Describe			ry/
th. Afte	Ş	1 X Natural 2 Accident	5 Pendi		(Month,	Day Year)	Injury	М		k? Yes 2 □ N			. ,		
Atten deal ctor: y the	fica	3 🗌 Suicide	6 □ Could determ	not be	e. Place of	f Injury - At	home, farm, st					28f. Location (Street and N	umber or Rura	al Route Number,
after after Dire	Certification;	4 🗌 Homicide	Jeten		building	, elc. (Spe	cify)					City or To	wn, State)		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier	1 Certifyi	ng Physiciar	1: To the b	est of my k	nowledge, deal	h occurred	at the tin	ne, date and	d place, a	and due to the	cause(s) and	d manner as s	stated.
• Ho • Fur etely	edicai	(Check only one)	2 Medical	Examiner: (On the bas ind manne	is of exami	nation and/or in	vestigation	, in my o	pinion, deat	h occurr	ed at the time,	date and pla	ice, and due t	o the cause(s)
orthin orthin	Me	29b. Signature and	title of certifie	er .						e number			29d. Date si	gned (Month,	Day, Year)
->-0			an	ha	4	M.D			Da	950	5		Ju~	e 15,	2006
3		30. Name and addr	ress of person	who comple	ted cause	of death (It	em 23a) (Type.	Print)	1	٠, ٠	1				D =
		Yndh	ish 1	100	Man	305	5 HOD	pital	A	~ire	, (3)	ion 13	ww	ie m	2006 D 21061
St	ate	31. Date filed (Mon	nth, Day, Year)	32 Reg	istrar's Sig		r							
	rar		UN 2 0	2000	8		1 for								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June **Physician** Ralph Swaggerty 2006 5:15 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Nursing & Rehab. N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, May 9, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 233 50 1829 128M 2□F 70 West Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2K No Maryland Anne Arundel Baltimore 10e. Street and Number 10g. Citizen of What Country? U.S. 121 Camrose Avenue 21225 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Itsm 27 is marked other then "naturel", or its ury or other traumatic event, the Medical Examina 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Binder Books 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (not available) (not available) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar important: if itsm 27 is any injury or other traugues. Bobby Edwards / Friend 121 Camrose Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State Baltimore, Maryland Bavview Crematory 6/16/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a Fart1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocordial **Physician** /Medical Due to (or as a consequence of): Examiner Cormin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CVA 1 Yes 2 No 3 Probably 4 High-known 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 2 □ No 1 Yes 2 ₩ 1 ☐ Yes Attaches and a section of the funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 | Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATERN A. AWAN 2717 HAMMINOS FERRY RUAD BALTIMAE NO 21227 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 0 2006

06-04079 John Sieracki

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month John S. Sieracki 0420 hrs June 14, 2006 **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore Harbor Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Months Days Hours Director 175 24 7595 80 May 1, 1926 PA. 1 X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits any 10a. State 10b County 1 X Yes 2 No Baltimore N/A items 23a or 28a-f show ist be notified at once. Marvland hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number U.S. 21225 807 Washburn Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes White 1 Yes 2 X No specify: Specify If Yes, Give Year WW II 4 Divorced Widowed "natural", ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Flementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical E Mechanic Domino Sugar Baltimore, MD 21215-0036 12th 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Joseph Sieracki Helen Wesolewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 807 Washburn Avenue Doris M. Sieracki / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 6/17/2006 Cedar Hill Cemetery Other Specify Donation 5 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway namunush Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only one c Death /Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical AMENDED item#23a,27,perME,g856,6/23/06 TT X UNPENDED signed by the attending physician be detached for use as the burial of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify: 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 V No certificate 26 Place of Death (Check only one) Hospital or Attending Physician: 25 Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 Other. 1 / Inpatient 2 ER/Outpatient 3 this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27 Manner of Death Certification: 24 hosping.

24 hours after death.

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ented in by the fu 1 X Natural Yes 2 No Division 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifie June 15, 2006 O.C.M.E. 30 Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Person JUN 2 0 Registrar

			State of N		artment of Healt		al Hygie	_ Z U U b	19395
	Physicia /Medic	an al	Decedent's Name (First, Middle, Last) Thomas Leonard Saylor		T 2. 2	Jur	te of Death onth ne 16,	Day Year 2006	3. Time of Death 9:15 A M
	Funeral	C1	1 ™ M 2□ F	Age (In yrs. last birthday,	4b. City, Town, or Local Edgewood If Under 1 Year If Ur Months Days Hot	nder 24 Hrs. 8. Da	te of Birth onth, Day, Yo	Harford 9. Birth	hplace (State or Foreign untry)
	Director		212-48-8361 Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	Ju	ne 28,	1946 Per	nsylvania 10d. Inside City Limits
	n the Maryl r 28a-f sho	Irector	Maryland Harford 10e. Street and Number	Edgewoo	10f. Zip Code		10g	. Citizen of What Co	1 ☐ Yes 🏋 No untry?
036	be filed within 72 hours after death with the Marylend Ital Hygiene. Id other then "natural", or Items 23a or 28a-f show event. Its Medical Franinal must be notified at	by Funeral Director	18.08 John Drive 11. Marital Status 1 Never Married 2 Married 1 Status 3 Widowed 4 Divorced 12. Was Deceder Armed Force 1 Yes 2 Status 1 Yes 2 Status 1 Yes 2 Status	s? JNo X	21040 Was Decedent of Hispanii If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No Spe	c Origin? (Specify Y xican, Puerto Rican, ecify:	es or No- etc.)	14. Race - Ame Black, White Specify:	
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	nd 2 allth ar 27 is		19a. Informant's Name/Relationship (Type, Print) Sadie Saylor - Wife	1	ing Address (Street and Ni John Drive,				
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Star 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of imatory or other place) Service Corp	Date 6/19/0		c. Location - City or Swson, Mar	
Balti	permit, Pages Department of I Important: If its any injury or o'		21. Signature of Funeral Service Licensee		2. Name and Address of F			neral Hom lon, Maryl	
	Physician /Medical		23a. Part . Enter the disease, or complication, that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (er.	sed the death. Do not en line.	iter the mode of dying, suc	nets	iratory arrest	,	Approximate Interval Between Onset and Death
68760, 🖈	death certificate be executed as estending physicien and ad for use as the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):					
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Division	7 2 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, s etc. (Specify)	treet, factory, office		cation (Streety or Town, S	et and Number or Ru State)	ıral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) 1	s of examination and/or i					
	To th To th	Me	29b. Signature and title of cartifier		29c. License num		29d	Date signed (Month	h, Day, Year)
	Ψ		30 Name an a sso pe n who completed cause of	of death (Item 23a) (Type	Print)	Havre	De	Grace, W	D 21078
D	Sta Regist		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	land.	•		,	

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** C. Frederick Schuman 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City_Town, or Location of Death Examiner HIMOX 8. Date of Birth (Month, Day, Year) March8, 1931 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In rs. last birthday) **Funeral** Days 1 X M 2 ☐ F 217-26-6988 MĎ Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or 102 Yawmeter Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★☆ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or item 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: SpecifWhite À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Crown Cork College (1-4or 5+) Elementary/Secondary (0-12) Line Operator Seal Company 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Schuman Louise Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an.
Important: if Item 27 is m.
any injury or other Karen Demanovich/daughter 117 North Marlyn Ave. Baltimore 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Cemetery 6/21/06 Baltimore MD 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service License Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death-shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence physicien and s the burial-transit The law requires that the death certificate be executed Due to (or all a consequence of) that initiated events resulting in death) Last Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the et d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Atter this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? al or Attending P s after death. I Director: Atter t d in by the tunera 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier 00062373 MO completed cause of death (Item 23a) (Type, Print) 30. Name and address of 9000 Franklin Square Drive Baitimore, Md 21237 32. Registrar's Signature 31. Date filed (Mc

State Registrar

			For State Ragistrar	State of Ma	-	epartmen Certificate			ınd Me		giene Rag. No.	2006	19397
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	and W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
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	5	- For State Registrar			Cer	tificate of	Death		_			No. 2	006	1939
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Xaiiiiiioi		or condition resulting in death	Due t	to (or as a cor	nsequence o	f):								
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1	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	d C.	to (or as a cor	nsequence o	f):							-	
executed an and al - transit			d											
e e e	edical	UNPENDED		MENDED								102d Data of	daliuani	
Box 68760 e death certificate b the attending physical for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant i past 12 months?		Bc. If yes, outo	come of preg		tal death	3	Ectopic	pregnanc	у	23d. Date of Month	Day	Year
ox 687 eath certific	sicia		Unknown 9	Pregnant Unknown	at time of de	eath 5 Ot	ner (Speci	fy)						
O. B. t the de by the	Phy	Part II. Other significant cor				esulting in the u	nderlying	cause giv	ven in Par	t I.	23e. Did tol	bacco use contril	oute to the	cause of death?
i, P.O. ires that the signed by	d by										1 Yes	2 V No 3	Probab	ly 4 Unknown
cords aw requi has been 2 should	olete								_		24a. Was a autops	sy p	nor to com	sy findings available pletion of cause of
tal Records cian: The law requi certificate has been ector, page 2 should	Completed										perform		eath? Yes	2 No
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to med examiner?	dical [Hospi	ital: .					of Death (0 Other			Residence 6	Othor: S	•
of Vir ing Physi After this uneral dir	ျ	1 Yes 2 No 27. Manner of Death		28a. Date of I	njury	ER/Outpatient 28b. Time of I		<i></i>	at Work?	2	Bd. Describe h	now injury occurre		cerie
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1							į.							
IVISIOR or Attence after death Director:	ifica	3 Suicide 6 (nvestigation Could not be	28e. Place of	f Injury - At h	ome, farm, stre	et, factory,	office bu	ilding, etc		or Town, St	tate)		Route Number, City
Di spital hours a neral 1	Cert	4 Momicide	letermined	(Specify)								rstown Road		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifyin one) 2 Medical	Examiner: On	the basis of e	xamination a	ige, death occur and/or investiga	red at the tion, in my	time, dat opinion,	e and plac death occ	ce, and di curred at t	ue to the cause he time, date a	e(s) and manner and place, and d	as started ue to the c	ause(s)
To T	Med	29b. Signature and title of ce	and	manner state	ed			License				29d. Date signe		
		/ahul	1009	49.				O.C.N	1.E.			June 16, 20	006	
74		30 Name and address of per					n Stroo	Paliti	more M	MD 2120	1 1			
7		Zabiullah Ali, M.D. 31. Date filed (Month, Day, Ye		nt Medical	trar's Signat	huro.		., Daill	TIOIE, IV					
Regi	itate strar	111110			eur.	15 60	vli							

Registrar DHMH 17 Rev 1/2001 JUN 2 0 2006

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

the Medical Examiner must be notified at

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nu any injury or other traumatic event, tre Media 2006.

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the ettending physicien ned for use as the buria

been signed by the should be detached

page 2

death certificate be executed

Box 68760.

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Division of Vital Records,

Hospital or Attending Physician:

To the

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To the Funeral C

completely filled i

filled in by

/Medical

death

within 72 hours after

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 11:00 A M DOROTHY THORN JUNE 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTI MURG BAYUSEW MEDSCAL CENTER N/A JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☑ F Yrs. 73 Director Feb. 17,1933 Pennsylvania 165-26-1850 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28s-1 show any njury or other treumatic event. Its Medical Examiner must be published at 9006. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 21 No Director Maryland Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6514 North Point Road 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Hall Charles A. Cassidy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harold C. Thorn (Husband) 6514 North Point Road Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 6/17/2006 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. inature of Funeral Service bicensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** URINARY TRACK INFECTION 1 DAV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 DAY SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sicion and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physicien Physician/Medical ed by the attending phys detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 3/ No 1 ☐ Yes 2 00 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Ampatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ME) ICA (RES-000 JUNE 14, 2006 lew DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INGELMO DR CHRISTOPHER 4940 EASTERN AUENUE BALTIMORE, MD 21224 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2006 Registrar

			for State Registrar	State of M	aryland / De _l	oartment of F ertificate of			giene Rag. No.	6 19401
**	Physici		Decedent's Name (First, Middle, Las HELEN		RENT			2. Date of De Month JUNE	13 2006	3. Time of Death
1 m .	/Medio Examir		4a. Facility Name (If not institution, give	ГН		LAUREL	r Location of Dea		4c. County of E	eath
*.	Funeral Director		5. Social Security Number 6. Security Number 409 46 2289	9X 7. A(□M 2⊠F	ge (In yrs. last birthda 78 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	Birthplace (State or Foreign Country) nnessee
	Ba-f show	Director	10a. State 10b. County MARYLAND ANNE ARUNE)AL	10c. City, Town or					10d. Inside City Limits 1 X Yes 2 □ No
	with the	Dire	10e. Street and Number 333 EAGLE HARBOUR SOUT	-и		10f. Zip Code 20724			10g. Citizen of What	,
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show arry fajury or other traumatic event, the Medical Examination and Landing and once.	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ঐ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Tes 2 Tes If Yes, Give Year or Dates:	No	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Pue	Specify Yes or No	Black, V Specify: W	merican Indian, /hite, etc. HITE
121	d within 72 t jiene. r then "net	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		5+) (Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire .RY WORKER	during most of we	orking	16b. Kind of Busine	ŕ
yland ;	2 should be filed and Mental Hygi Is marked other raumatic event, t	To Be C	17. Father's Name (First, Middle, Last) ALFRED MCKINLEY LASTER	}			18. Mother's Na		, Maiden Surname)	J.,,,,
Mar	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationship (7 CAROLYN TRENT/Daughter			iling Address (Street LOTTIE FOWLE		RINCE FREDI	er, City or Town, Stat	No.
ore,	Pages 1 and 3 nent of Health ant: If Item 27 ary or other tr		20a. Method of Disposition 1	Removal from State	20b. Place of Dis cemetery, c		ce)	Date /2006	ERICK MARYL 20c. Location - City COLUMBIA, M	or Town, State
Baltii	permit. Page Department Important: If any Injury o		21. Signature of Fundral Service Licens			22. Name and Addre	ss of Facility			UREL MARYLAND
	Physician /Medical Examiner purual-transit	Examiner	23a. Part1. Enlife the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Carcinom Due to (or as b. Metastat Due to (ur as Chronic	na of the Lur a consequence of): ic Disease a consequence of). Bronchitis	·	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 4 Months
Box 687	ath certificate ttending phys or use as the	Physician/Medical E	IE EEMALE:	d. 23c. If yes, outcome 1 Urive birth 4 Pregnant a	2 Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	,		23d. Date of Month	delivery Day Year
P.0	y th	ρ	9 ☐ Unknown Part II. Other significant conditions co	9□ Unknown	out not resulting in the	underlying cause giv	en in Part I.		_	e to the cause of death?
Division of Vital Records,	The law requires that ite has been signed b rage 2 should be deta	Completed	Hypertention					24a. Was autop	an 24b. Were	
/ital	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?			3-0 x 1-0 0-0	26. Place of De	eath (Check only o		03 2 3 110
ion of \	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 ☐ Inpati 28a. Date of Inji (Month, Da	ury 28b. Time	of 28c. Injur	4 🗀 Nursing		dence 6 Other (S	Specify)
Divis	ital or Atters after des ral Director led in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Place of m	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (City or Tox	Street and Number or wn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Examone) 29b. Signature and title of certifier	vsicien: To the best iner: On the basis of and manner st	of examination and/or	ath occurred at the til investigation, in my o	pinion, death occ	curred at the time,	cause(s) and manner date and place, and of 29d. Date signed (Mi	due to the cause(s)
)	or with		•	lown	Joseph (Heart 22a) (True	D13671			JUNE 13, 2006	
	Y		30. Name and address of person who of B.G. MANEJWALA, MD 14		PARK DRIVE S		UREL MARYL	AND 20707		
	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 2 0 2006		rar's Signature	t i				

				ype or Print State of Man	uland / Dena	artment of H	ipalth and M				19402
			1 - For State Registrar Amend Item	#13 per An	a Bd g850	stific9916/06	Death		Reg. No.		
	Physicia		 Decedent's Name (First, Middle, Last) Kenneth Taylor 					2. Date of De Month June	Day	Year 2006	3. Time of Death 8:54ам
	/Medic Examin		4a. Facility Name (If not institution, give s Joseph Richey Hos			4b. City, Town, or Baltimo	Location of Death		4c. County		
	Funeral		Social Security Number 6. Sex	7. Age (/	n yrs. last birthday)		If Under 24 Hrs.	8. Date of Bir (Month, Da March (th V-Year)	9. Birthplac	ce (State or Foreign
	Director		220-54-0098 X Usual Residence of Decedent	1M 2□F 56	Yrs.			March (1950	Mary]	and
fanyland	show	ō	10a. State 10b. County MD	10	Oc. City, Town or Lo					10d	Inside City Limits 1 Yes 2 No
with the N	a or 28a-1 Le notifi	Direct	10e. Street and Number 838 N. Eutaw St.		Daitimor	10f. Zip Code 21201	<u>. </u>		10g. Citizen of W	Vhat Country	/?
JSO urs after deeth	of Health and Mentat Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Nedical Exeminating by invitiled at	by Funeral Director		12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1900-	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	. 14. Race Black Specify.		Mhite
4 1 4 1 3-0030 d within 72 hours af	iene. r than "natura Ine Medical E	Be Completed	15. Decedent's Educing (Specify only highest grade Elementary/Secondary (0-12) 12	completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of worki	unk	16b. Kind of Bu	siness/Indu	UNK
yland ,	Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Chester T	Taylor			18. Mother's Name	Marie E	vans		
Mary id 2 sho	Ith and It		19a. Informant's Name/Relationship (Ty, Laddaka Wilson/dau		19b. Mailir 1012 N	ng Address <i>(Str</i> eet Noland Dr	and Number or Rura • Hagerst	own, MD	er, City or Town, S 21740	State, Zip C	ode)
nore,	ant of Hea it: If item: y or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 ☒ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	(e)	Date	20c. Location ·	City or Towr	n, State
permit. Pages	Department of H Important: If ite any injury or ot or ce.		21. Signature of Funeral Service License	4	Si Ba	2. Name and Addre tate Anat altimore,	ss of Facility Omy Board MD 21201	655 W.	Baltimo	ore St	reet
Ph	nysician		23a. Part 1. Enter the disease, or come in shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	e death. Do not ent					Ir	pproximate hterval Between inset and Death
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oU, be executed	sician and burial-transit	al Examiner	rit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):		<u> </u>			le	nknows
Geath certificate	e attending phy: d for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 3c. If yes, outcome of particle of the street of the	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	e of delivery onth Da	ay Year
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a tav	cate has be page 2 sho	Completed						24a. Was autor perfo 1 Yes	rmed? d	Vere autopsy rior to comp eath? Yes 2	y findings available letion of cause of
VITE	s certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA Oth	26. Place of Death er: 4 \(\text{Nursing Ho} \)			or (Specify)	Hospice
ION OI	ath. r: After th e funeral	ation: T	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of	f 28c. Injur Wor			now injury occurre		
DIVISION I or Attending	after des Directo	Certificatio	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rural A	loute Number,
Hospitel	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	edical C	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of ner: On the basis of ex and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and mar date and place, a	nner as state and due to th	ed. e cause(s)
To th	within To the	Me	29b. Signature and little of certifier Haruld C	thichho) 56mft	29c. License	number	2	29d. Date signed		, ,
			20 Name and address at person who as	moleted sauce of deat	th /Itam 23a) /Tupa	Print\	, 1 7 8	<u> </u>	6/	6/6) (
Wiles.	Sta	ate	Harold C 31. Date filed (Month, Day, Year) JUN 1 9 26	Standrho 32. Pagistrar's	Signature _	Proceed &		· · · · · · · · · · · · · · · · · · ·			
	Registr		JUN 1 9 20	006	w Sir Kg						

			For State of Maryland / Dep State Registrar State of Maryland / Dep	artment of Health and Mertificate of Death		ene 2006	19403
	100		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Dorothv M. VIZZAR	ī	June -	18, 2006	12:30P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jane	4c. County of Death	12.001
		類	H.C.R. Manor Care	Towson		Baltimore	2
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthpl Coun	ace (State or Foreign
	Director		1/4-16-90//	Noning Bays Tions	Aug. 1,	1919 Penn:	sýlvania
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		11	Od. Inside City Limits
	sho	5					1 ☐ Yes 2 🔀 No
	28e-f	Directo	Maryland Baltimore Towson 10e. Street and Number	10f. Zip Code	100	. Citizen of What Coun	
	with with Dec			21286		U.S.A.	.,.
	leath	Funerai	509 E. Joppa Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - America	
0	r Iter	필	1 Never Married 2 Married 1 ☐ Yes 2 📆 No		Rican, etc.)	Black, White,	etc.
3	hours after death with the Maryland turel; or Items 23a or 28e-f show at Examinan must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specity:		Specify: WI	nite
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Hygiene. de Hygiene. de Other than "naturel", or tems 23a or 28e-f show event, tra Masical Examinar must be notified at event,	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation s kind of work done during most of work	ing 16	b. Kind of Business/Inc	lustry
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Z	filed within 72 Hygiene. Other than "na ent, it a Medic		12	Cook	e (First, Middle, Ma	_Restauran	<u> </u>
מש	be fill	Be	17. Father's Name (First, Middle, Last)				
Š	should nd Mer marke	ို	Domenico Folcarelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run	Jane	Palmucci	Code
<u>8</u>	s 1 and 2 shou f Health and M frem 27 le mar other traumat			8 Kilkenny Circle			
	s 1 an if Heal Item 2 other		20a Method of Disposition 20b. Place of Disp	osition (Name of		c. Location - City or To	
<u>ō</u>	0 0		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Calvary	matory or other place)	-2006 A1	toona, Peni	nsvlvania
Baltimore,	permit. Pag Department Important: eny Injury c once.			22. Name and Address of Facility Ru			
ñ	Ped of the call			050 York Road, To			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one bause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	A			Onset and Death
ř	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	V J		> 5	461
	Examiner		Sequentially list conditions b.	. 1/			211000
	ק # <u>#</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, ,		> 0	9 EU./
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			-	/
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687	phys s the		d				
	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
Вох	death e ette d for	icia	in the past 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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a, D	The law requires that the death certificat ate has been signed by the ettending phypage 2 should be detached for use as the	by Physician/Med	Part It. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	
Records,	w require been sig				1 🗆 Yes	2 No 3 Prob	ably (Cinknown
ပ္မ	law re as be 2 sh	Completed			24a. Was an autopsy	prior to con	osy findings available
_	The ate h page	Corr			performe	d? death? No 1 ☐ Yes	2 🗆 No
Vital	cian: ertific actor,	Be (25. Was case referred to medical examiner?		h (Check only one)		
5	Phyeician: The lav this certificate has al director, page 2	2	Hospital: 1 Inpatient 2 ER/Outpatie			e 6 ☐Other (Specify)
й	ing F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	intury occurred	
<u>s</u>	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f Location (Street	et and Number or Rura	Route Number
Division of	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	1001, 1201017, 011100	City or Town,		
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ith occurred at the time, date and place,	and due to the caus	se(s) and manner as st	ated.
	P Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, I	Day, Year)
)	10			1147726	1-	5-19-	0/
1	4 1		30. Name and address of person (ma completed cause of death (Item 23a) (Type	_	Ma 5		
_	1		114111111111111111111111111111111111111	er.Dr. 411 lowson	, MD 3	1/204	
1	Sta	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hack .			

Amend #17&18 Per State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year JUNE 2006 1425 /Medical 16 Frances Wilson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** Birthplace (State or Foreign Country) Months 1□M 2☑F Director 66 07 218-36-9987 Usual Residence of Decedent 39 23 MD within 72 hours aftar death with tha Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "neturel", or items 23a or 28a-f sho treumetic event, the Medical Examiner must be notified at Directo 1X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5003 Cordelia Ave 21215 by Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed ★☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Accounting Dept. 17. Father's Name (First, Middle, Last)

Battle Equitable Bank To Be 18. Mother's Name (First, Middle, Maiden Surname) end Mantail Charmes Charles W. Dattle Elizabeth Carmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Mabry-Daughter 1668 Burnwood Road, Baltimore, Md 21239 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Pagas 1 20c. Location - City or Town, State Dapartment of important: If it any injury or o 1 ☐ Burial 2/☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 6/24/06 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIOMYOPATHY YEARS Examiner Due to (or as e consequence of): Examiner MITRAL REGURGITATION 50 YEARS ettending physician end for use es the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the pega 2 should be detached 23b. Did tobecco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 □ Probably 4 □ Unknown CURONAR ARTER DISEASE þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Thai 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attanding 1 Matural 5 Pending investigation aftar death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) aftar 4 Homicide To the Hospital c within 24 hours a: To the Funerel E complately filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Peter W. Cho SURGEON D41129 JUNE 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2435 WET BELVEDERE AVENUE BALTIMONE, MD 21215 PETER W. CHO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 0 2006 Registrar

MILSON, FRANCES

	•	For State	S	tate of Ma	ryland /		rtment			Mental Hy	6	006	19405
		Ragistrar 1. Decedent's Name (First, Midd.	le Last)			Oei	incate	UI De		2. Date of De	Reg. No.		3. Time of Death
Physici	an	Frankli		(la)	imme					Month	Day	2006	
/Medi		4a. Facility Name (If not institutio				-	4h City To	own artoc	ation of Death	Jun		County of Deatl	
Examir	er	University of M			lical 6.	nter			5m21		40. 0	NIN	
Funeral		5. Social Security Number	6. Sex		(In yrs. last b		If Under 1	Year If L	Inder 24 Hrs.		rth	9. Birtl	hplace (State or Foreign
Director		214-20-6159	™ M	2 🗆 F	79	Yrs.	Months I	Days Ho	ours Min.	8. Date of Bi	3/19	26 Ma	untry) aryland
D _		Usual Residence of Decedent			10. 0. 7								
arylar show	_	10a. State 10b. County			10c. City, To								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
88a-f	Director		timor	re	Pa	rkv	ille				-		
with the or 2 be n		10e. Street and Number 3319 Woo	aci ac	λιτορι	10		10f. Zip C					en of What Co	untry?
ITIQ X IX I 3-UU30 be filed within 72 hours efter deeth with the Maryland lat Hygiene. d other then "natural", or items 23a or 28a-f ehow event, ite Madicial Examinar must be notified at	Funeral	•		Was Decedent B		12 1		1234	io Origin? (S	pecify Yes or No		USA 4. Race - Ame	dean Indian
ter d	'n,	11. Marital Status 1 □ Never Married 2 Nav		Armed Forces?		13. 1	f Yes, specify	Cuban, M	exican, Puert	Rican, etc.)		Black, White	
ours of	þ	3 ☐ Widowed 4 ☐ Divorced	d	1 ☑ Yes 2 🗀 N If Yes, Give Year or Dates:		1	l∐Yes 2₹	No Sp	ecify:		5	Specify: whi	ite
within 72 hours efter ene. then "natural", or ite		15. Deceder			16		lent's Usual (/.:= -	,	d of Business/	
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or th	Con	12				Qua	lity	cont	rol		Wes	tingho	ouse
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laryland 4 14 12 12 should be filed within and Mental Hygiene. Is marked other then sumatic event, items	2	Louis Wim								lda J.			
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rre, Maryla s 1 end 2 should if Heelth and Men item 27 is marke other traumailc		Helen Albre	ent -	- siste			NOTE sition (Name		odwar	d Dr.		imore,	MD 21221
Dalkimore permit. Pages 1 Department of P Important: If its eny injury or ot once.		1 Burial 2 ☐ Cremation		oval from State	Gard	tery, cren	OF F tery	er place) a i th	Jun	e 19,			
Saltimor Pages Department of mportant: if it ny injury or o		4 Donation 5 Other (Care							edale,	
Da Demi		21. Signature of Funeral Service	Licensee				Name and		al Ho	8800 Par	Har: kvil	ford F	21234
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		shock, or heart failure. Lis Immediate Cause (Final	t only one c	ause on each lin	е.						irest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	_ a	Heur	e Mi	1010	gensi	اسا ی،	enkei	nia			Imonth
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	Je.	Sequentially list conditions, if any, leading to immediate	b	Due to (or as	consequenc	e of):							
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ate be ex hysicien the burial	dical		d										
as as	Ned	IF FEMALE:											
BOX ath cer attendir for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c.	If yes, outcome of 1 ☐ Live birth		th 3□	Ectopic preg	nancy			23	3d. Date of deli Month	4
. 0 .0	sici	1 Yes 2 No		4□Pregnant at 9□ Unknown	time of death	5	Other (spec	ify)				MOHIII	Day Year
Hecords, F.O. The law requires that the drift has been signed by the bage 2 should be detached		Part II. Other significant condit	ione contrib	uting to death h	it not reculting	in the	ndorhina onu	so owoo in	Do et l	230 Did	tobacco un	n contabuto to	the cause of death?
signe t be d	ğ	Cellulitis	IONS CONTIL	dung to death bi	it not resulting) III (III UI	nderlying cau	ise given in	raiii.		Yes 2		
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e law hes b	Completed									24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
VICAL HEC sicien: The law certificete hes b irector, page 2 s										1 □ Yes	2. No	1 Yes	2 🗆 No
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ding F	章	1. Sinatural 5 ☐ Pendi		(Month, Da)	Year)	Injury	м	Unjury at Work?	2 🗆 No	200. 2030100	now injury	occurred	
DIVISION i or Attending after death. Director: Afte	fica	3 ☐ Suicide 6 ☐ Could	I not be	28e. Place of Inju	ıry - At home.	farm, str				28f. Location	Street and	Number or Ru	iral Route Number.
UIVISION OF VITAL al or Attending Physicien: T s after death. if Director: After this certificet and in by the funeral director, ps	Certification:	4 Homicide	TIII IOG	building, etc	. (Specify)		, ,,			City or To	wn, State)		
To the Hospital or within 24 hours affe to the Funerel Dir completely filled in		29a. Certifier 12 Certify	ing Physici	an: To the best of	of my knowled	ge, death	occurred at	the time, d	ate and place	, and due to the	cause(s) a	and manner as	stated.
n 24 n 24 or Fu	edical	(Check only 2 Medica one)	l Examiner	On the basis of and manner sta	examination ted.	and/or in	vestigation, ir	n my opinio	n, death <i>o</i> ccu	rred at the time	date and	blace, and due	to the cause(s)
To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	ž	29b. Signature and title of certific	er	1	0			License nur				signed (Monti	
		Honuth	un i	tenpe	y, m	>		1189	587)	une 1	5,2006
111		30. Name and address of person	n who comp	leted cause of de			Print)						
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	ate	31. Date filed (Month, Day, Year		32. Resistra	ar's Signature								21201
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DHMH 17 Rev 1/2	2001			-									

DHMH 17 Rev 1/2001

Registrar

JUN 2 0

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 7:10PM **Physician** ear 2006 Wiser /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** BAYView N/A Baltimore Care Center 8. Date of Birth (Month, Day, Year) May 23, 1909 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 M 2 F 212-07-9730 **Director** 97 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County 23a or 28a-f show the Medical Examinational be notified at 1 AYes 2 No Baltimore City N/A Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 419 Elrino Street r death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Items filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: White Completed by 3 X Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) then Elementary/Secondary (0-12) other then Confectionary Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental sut: If item 27 is marked o Molly Behnke Clarence Orwig 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 363 Long Meadow Way, Arnold, Maryland 21012 Kathy Janssen/Niece f Health a other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 06/20/06 Baltimore, Maryland permit. Page Department of Importent: If any injury or once. Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. ice Licensee 21. Sonature of Funeral Se 6224 Eastern Ave., Baltimore, Maryland 21224 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final years Pnysician ementio. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 - No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Chursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death After 5 Pending investigation 1 Hatural 1 TYes 2 No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 - Artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Kins BAY Wes Circle Bothmere MD 4224 State Registrar

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

MD

Funeral

Diréctor

or than "natural, or items 23s or 28s-1 show the Medical Examiner must be notified at

the Manyland

within 72 hours after

nd Mental Hygiene. marked other than

Department of Health and Mental Hyg important: if Item 27 is marked other any injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

signed by the e

peeu has

filled in by the funeral director,

within 24 hours after deat To the Funerel Director:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only or	ne cause on each line.	it officer and the	do or dying, soon as cardie	ic or respiratory i	arrest,		Interval	Between
Immediate Cause (Final disease or condition	Sepsis							and Death
resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of IMMUNO SU PP	ress10						days
Cause (Disease or injury that initiated events resulting in death) Last	Acute Myelog & Due to (or as a consequence) of	enous):	Lcukemia				9 m	onths
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic p 5 □ Other (s			2	3d. Date of dei Month	ivery Day	Year
Part II. Other significant conditions cor	tributing to death but not resulting in t	he underlying	cause given in Part I.		tobacco us	e contribute to		of death?
				24a. Was auto perf 1 Yes	omed?	death?	topsy findir completion 2 \(\subseteq \text{No}	ngs available of cause of
25. Was case referred to medical examiner?			26. Place of De	ath (Check only	one)			
1 ☐ Yes 2/2 No		atient 3 D	OA Other: 4 Nursing I	Home 5 ☐ Res	idence 6	Other (Spec	cify)	
27. Magner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Tir Inj		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, facto	ry, office	28f. Location (City or To	(Street and wn, State)	Number or Ru	ıral Route M	√umber,
29a. Certifier (Check only one) Certifying Phys	sician: To the best of my knowledge, ner: On the basis of examination and/ and manner stated.	death occurred or investigation	d at the time, date and plac n, in my opinion, death occ	e, and due to the urred at the time,	cause(s) a , date and	and manner as place, and due	stated. to the caus	se(s)
29b. Signature and title of certifier		29	c. License number		29d. Date	signed (Monti	h, Day, Yea	r)

The Johns Hopkins Hopital, 600 North Welfestreet, Baltimire, Maryland 21287

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

filelier It food

Yolanda Hendley 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

06-03676 Dave Anderson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of De	ath	Re	g No 200	6 1910
Physicia ledical Exami	ın/	Decedent's Name (First, Middle, Las	t)			2 Date of Death Month	Day Year	3. Time of Death 0543 hrs
ieuicai Examii	liet	Dave Anderson 4a. Facility Name (if not institution, give	e street and number)	4b. C	ty, Town, or Location of D	May 30, 20 Death	4c. County of Deatl	
		1700 North Mount Street		Ba	Itimore			
Funeral		5 Social Security Numberunk 6. So			Under 1 Year If Under 2 Onths Days Hours	4Hrs 8. Date of Birth	h(MM/DD/YYYY) 9 Bir Foreig	thplace (State or unk
Director			M 2 F 53	Yrs		Jan 8,	1953 ^{co}	untry)
any	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d Inside City Limits
*	칟	MD		Baltimor	e			1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number		10f	Zip Code	10	g Citizen of What Cou	ntry?
ith the		1700 N. Mount 11. Marital Status unk		C 13 Wes Day	21217	2 / Casada Van ar Na	USA	inna Indian Biasi
bours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married	Armed Foreces 113		pecify Cuban, Mexican, Pu		White, etc.	ican Indian, Black,
after d	by Fi	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		2 X No specify		Specify bl.	ack
hours 'natur	eted t	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's Us during most of	ual Occupation (Give kind working life, DO NOT use	d of work don enk e retired)	16b Kind of Business/	Industry unk
36 hin 72 e. than '	ple		ink					
5-0036 iled within 7 Hygiene. I other than the Medica	Comple	17. Father's Name (First, Middle, Last			unk 18 Mother's N	Name (First, Middle, M	laiden Surname)	unk
21215-0036 Muld be filed within 72 Mental Hygiene. marked other than "	o Be	19a Informant's Name/Relationship (1	Tuno Brint)	10h Mailing Add	socs (Street and Number	s as Dural Davida Num	has Oile as Tarres Otalia	7 - 0 - (1-)
MD 2 d 2 shoul Ith and N n 27 is m numatic	ř	O.C.M.E.	ype, Filit)	4	ress (Street and Numbe enn Street		-	e. Zip Code)
= p = e =		20a Method of Disposition		Place of Disposition crematory or other pl	Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hes mportant: If ite		Burial 2 Cremation 3 Donation 5 X Other Specify	Nemoval Irom State	rematory or other pr	decy			
Baltimo permit. Pag Department Important: injury or of		21. Si partie of Ronald Service Licer	Wave Director	State	and Address of Facility Anatomy Bo	ard 655 W.	Baltimore	Street
Physician	-	23a Part I. Enter the disease, or comp	plications that caused the death.	7 Balti	more, MD 2	1201		Approximate Interval
Medical.		fature. List only one cause on e Immediate Cause (Final disease a.			, 5.			Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence of					
	ŗ.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	n·				
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ansit	Exa	events resulting in death) Last	Due to (or as a consequence of	1)				
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760, ficate be ex g physician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr				23d Date of deliver	
Box 68 death certifine attending	sician	past 12 months?	1 Live birth 4 Pregnant at time of dea		eath 3 Ectopic pr	regnancy	Month I	Day Year
Bo ne deat the att	Phys	1 Yes 2 No 9 Unknow	a ouknown			100-101111		
, P.O. res that the signed by be detach	þ	Part II. Other significant conditions Cocaine use	contributing to death but not re	esulting in the under	lying cause given in Part I	1 Yes	bacco use contribute to	pably 4 V Unknown
rds, require been sig	Completed					24a. Was a	n 24b. Were au	itopsy findings available
Records, The law requir ficate has been s	mpk	-				autops	med? death?	completion of cause of
ital Recionant The scentificate		25 Was case referred to medical			26 Place of Death (Cf	1 Yes 2	2 No 1 Y	es 2 No
Division of Vital ral or Attending Physician: 13 after death at Director: After this certiled in by the funeral director	o Be	examiner? — 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other N	lursing Home 5	Residence 6 🗸 Othe	r: Scene
n of ling Pt After funeral	on: T	27. Manner of Death 1 Natural 5 Dending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	
ivisior or Attend after death Director: I in by the	catio	2 Accident Investigat	290 Place of Injury At he	Fnd 5:43 am	1 Yes 2X N		treet and Number or Pu	ural Route Number, City
Divis	ertification:	3 Suicide 6 X Could not determine	be		bory, office building, etc.		ate)807 North M	
물 것 물 필	S	29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge			, and due to the cause	e(s) and manner as star	
To the Hos within 24 h To the Fun completely	edical		r:On the basis of examination ar and manner stated	nd/or investigation, i		rred at the time, date a		
	Σ	29b. Signature and title of certifier	N 10.		29c. License number O.C.M.E.		29d Date signed (Mo	inth, Day, Year)
		30. Name and address of person who	completed cause of death (Hom	(23a)	O.O.IVI.L.		ay 00, 2000	
			istant Medical Examiner		treet, Baltimore, MD	21201		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	J. Jack	N. 9		 -	
Regis	urar	JONAT	2006	20 - Maria				

Please Type or Print in Black Indelible Ink Mohamed Z. Awad State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No . Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death **Medical Examiner** June 19, 2006 Mohamed 1212 hrs Ζ. Awad 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13418 Blenfield Road Phoenix **Baltimore County** 5 Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. Director Months Days Hours Foreign Min M M 2 F 212**-**46**-**5483 Country) 80 03 Egypt Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shov e notified at once. Baltimore MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 273 marked other than "natural", or items 23a or 28a-f sho iljury or other transmatic event, the Medical Examiner must be notified at once. 1 Yes 2 X No Phoenix Director 10e, Street and Number 10g Citizen of What Country? 13418 Blenfield Road II.S Funeral 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 2 X Married Armed Forces? 1 Never Married White, etc. Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify þ Specify: Egyptian 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade 8yrs+ Medical Lab. Director Self-Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mohamed A. Awad Nazle Negm 19a. Informant's Name/Relationship (Type, Print) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ahmed G. Awad-Son 4141 Madonna Road, Jarrettsville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Other Specify: Donation 5 King Memorial Park 6/20/06 Randallstown, Md Signature of Funeral Savice License 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, JAMPAN Baltimore, Md 21215 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line **Physician** /Medical Between Onset and Carbon Monoxide intoxication Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g856,6/26/06 TT P.O. Box 68760, IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 VOther: Scene 1 🗸 Yes 28d Describe how injury occurred Carbon monoxide Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 5 Pending 1 Yes 2 X No Fnd 6/19/2006 Fnd 12:00 pm from car got into house

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial - transi Division of Vital Records, Medical

2 X Accident 3 Suicide Homicide 29a. Certifier 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

JUN 2 1 2006

29b. Signature and title of certifier

Could not be

determined

29c. License number O.C.M.E.

29d Date signed (Month, Day, Year) June 20, 2006

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 13418 Bienfield Road

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

2. Registrar's Signature

(Specify) House

31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Month 4:19 AM **Physician** John D. Allen 15 2006 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HealthCore St. Agnes 8. Date of Birth (Month, Day, Year) Dec. 1, 1933 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Hours Mary land 212-32-3513 Director Usuel Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1810 Woodside Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7 is marked other than traumatic avent, the Mis College (1-4or 5+) 12 warehouse Worker A and P Tea Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Orville R. Allen Flora Trevett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: if item 27 is any injury or other trau Margaret J. Lackey -= Sister 6219 Groveland Road Linthicum, MD 21090 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ment of F 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD June 16, 06 21. Signature of Funeral Service Licrosee

22. Name and Address of Facility
Cremation Society of Maryland, Inc.
23a. Part. Enter the disease, or complications that cause of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION Physician 10 hours /Medical Due to (or as a consequence of): Examiner CURONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached to Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown Mellitus 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificete 2 12 No 1 Yes Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No P ŏ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division Hospital or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MD (Resident) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Rubammerfalio P18612 JUNE 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Caton Avenue, Baltimore, MD. 21229. MUHAMMAD TALHA, MD 900 31. Date liled (Month, Day, Year) JUN 2 1 2006 32. Plugistrar's Signature State Beller Registrar

DHMH 17 Rev 1/2001

ALLEN

		-	For State Registrar	State of Ma		artment of F			giene Reg. No. 2006	19412
*	Physici		1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day Year	3. Time of Death
	/Medic Examin	al -	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	JONE	4c. County of De	
	*	A ST	5. Social Security Number 6. Se	SPLIAL	(In yrs. last birthday	SACT If Under 1 Year	Trunder 24 Hrs.	8 Date of Birtl	n 9 B	irthplace (State or Foreign
	Funeral Director			XIM 2□ F 68	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day Sept 2.	2, 1937	Mary Land
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary B-f sh	tor	MD Carr	011		Manches	ter			1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	e 23a	eral	4984 Wentz Road	12. Was Decedent E	ver in IIS 13		102	necto Yes or No-	USA	nencan Indian.
336	72 hours after death with the Maryland "natural", or iteme 23a or 28e-f show Jigal Examinan mast be notified at	by Funeral	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	0 '6	
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d 2	othe ent,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Maryland		To		harles	Belt AND MA	F	Emn			irts
Mar	2 2 2 2		19a. Informant's Name/Relationship (Carole B. Belt	урө, Print) Wife	ĺ	Wentz Ro		ester, 1	r, City or Town, State MD 21102	, Zip Code)
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cri	oosition (Name of ematory or other place	ce)	Date	20c. Location - City of	
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of	ng Phys fter this ineral dii	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day)		of 28c. Inju.	ry at rk?		dence 6 Other (Sp now injury occurred	pecify)
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	10	G	30. Name and address of son who	completed cause of de		a, Print)	SALL F	ME	るかかの	17, 2006 OLE, MD 212
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2, 1, 200		r's Signature	ede				

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Thomas Robert Becker	State of Maryland / Department of Health and Mental Hygiene
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		Registrar		Certific	ate of L	Jealii			Reg. No.	· · · · · · · ·	」し.) 1 3 4	
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date										3 Time of Death	_
ledical Exami	ner	Thomas Robert B	lecker					Month May 27,	2006	Year		1756 hrs	
		4a Facility Name (if not institution, g			4b	. City, Town, or L	ocation of Dea			c. County o	f Death		-
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daryland 28a-f show 1 at once.	윉	10e, Street and Number			1	10f. Zip Code		unk	10a Cit	izen of Wh	at Count	w?	_
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215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Compl		unk										
5-6		17. Father's Name (First, Middle, Las	st)			unk 18	8 Mother's Nam	ne (First, Middle	. Maiden	Surname)		unk	
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Jre, MD 21215-0036 ss 1 and 2 should be filed within 72 of Health and Mental Hygiene If item 27 is marked other than 'her traumatic event, the Medigal	2	19a Informant's Name/Relationship	(Type, Print)	198	b. Mailing A	Address (Street	and Number or	Rural Route N	umber, C	ity or Town	State, 2	Zip Code)	П
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두 명분 문 때	ı	20a. Method of Disposition	Υ			on (Name of cem		Date	_	Location -	City or T	own State	_
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Page Page ment iant:		4 Donation 5 X Other Specific	fy: in state										
		21. Signature of Fund al Service Lice Ronald S			22. Nar	me and Address	of Facility		-				7
Balt permit Depart Impor injury	ļ	mand.	Wade Direg	tor	Balt	me and Address de Anaton	my Boar MD 212	d 655 V	I. Ba	altimo	ore :	Street	
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Physician /Medical		failure. List only one cause on	each line.		, , , , , , , , , , , , , , , , , , , ,	mode of ajing, o		or reopriatory c		ook, or nea		Between Onset and	
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06-03656 Charles Beaty

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To To	Mec	29b Signature and title of certifier 29c License number	sa at the time, date		
		0.C.M.E.		29d Date signed (f	Month, Day, Year)
	-	30 N me and address of person who completed cause of o ath (Item 23		May 30, 2006	
	1	Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regist	rar	JUN 2 1 2006 pleases to species			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					f Marylar		partment ertificate			Mental Hy	Reg. No.	00	16	19415
	Physician /Medical	1. Decedent's Name	hel	B		2				2. Dete of De Month	eath Dey		Year 6	3. Time of Death 7 20 Av
	Examiner	4a Facility Neme (If n	oot institution, give Crest Ca						_	Location of Dea	th 4c.		of Death	
	uneral	5. Social Security Nur			7. Age (In yrs.	last birthda	ay) If Under 1	Year	Baltimo:	8. Date of Bi	rth	Ral	timore	
	irector	214-22-933		□M 2) (7) F	97	Yrs	Months	Days	Hours Min	. (Month, D 09/04	ay, Year) 1901	3	Mary Mary	ce (State or Foreign y) land
pur	3	Usual Residence of D	ecedent 10b. County		10c Cit	ty, Town or	Location							d. Inside City Limits
Maryte	1sho	MD	Baltimor	re		Balti							100	1 ☐ Yes 2 🔀 No
the the	a or 28a-1 show be notified at Director	10e. Street and Numb				DOT 61	10f. Zip C	Code			10g. Citi	zen of W	Vhat Country	y?
th with	23a o	8830 Walt	her Blvc	í.			2123	34			US	4		
ar dea	r items 23u iner must Funeral	11. Marital Status		Armed Fo		,S. 1	Was Decede If Yes, specif	nt of Hi y Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-		- American	
11215-0036 within 72 hours after death with the Maryland	by F	1 ☐ Never Married 3 ☑ Widowed 4		1 ☐ Yes If Yes, Giv Year or Da	'e		1 ☐ Yes 2 j	No No	Specify:			Specify.	: Wh	ite
2-06-2-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		1	5. Decedent's Ed	ucation		16a. De	cedent's Usual	Occupa	ation	dr. e	16b. Ki	nd of Bu	siness/Indu	stry
21. Eithir 7	ther than "nature it, the Madical Completed	Elementary/Second	only highest greatery (0-12)	College (1	-4or 5+)				furing most of wo	orking				
d 21	other th	17. Father's Neme (Fi	iret Middle (act)			Но	memaker	•	10 Motheric No.	ma (Finat Adiable	Admirator .		Home	
Marylanc 12 should be fi	items of the second of the sec	Charles		.nas						me (First, Middle cet Litz			e <i>)</i>	
ary	T T	19a. Informant's Nam	e/Relationship (7	ype, Print)		19b. Ma	ailing Address (Street a		ural Route Numb			State, Zip C	ode)
ore, M	n 27 li	Frederick	L. Beck	er, Jr.						Ijamsvi	lle,	MD.	2175	54
Baltimore, Maryland 21215-0036	or off	20a. Method of Dispos	Cremation 3 □	Removal from 5			sposition (Name rematory or oth			Date			City or Town	
Itim	important: If it and injury or o	4 □ Donation 5			Pa	rkwoo	d Cemet			23, 20			imore,	
Ba med	any le	11.00	7	Stepher	Costs	_								ome, Inc.
		23a. Part1. Enter the	disease, or comp	plications that ca	aused the deat					OWSON,		anu	A	pproximate
/N	rsician ledical aminer	Immediate Cause (Fit disease or condition resulting in death)	faiture. List only c	e	end.	- st	ege d	ev	rent.				i In	iterval Between Inset and Death
30	ě				Due to (c	ores a cons	sequence of):						į	
	physician and s the burial-transit Adical Examiner	Sequentially list cond	itions,	b. ———	Due to (a	r es a cons	sequence of):					_	I	
68760,	burial burial	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or injudinational that initiated events	ring jury	C									1	
		resulting in death) Las	st		Due to (o	r as a cons	equence of):							
Box (d by the attending letached for use a Physician/M			d					_				1	
B	the att hed fo	Part II. Other significa	ant conditions co	ntributing to de	ath but not res	ulting in the	underlying cau	ıse give	en in Part I.	23b. Did	tobacco	use con	tribute to th	ne cause of death?
G. that	ed by detac									10	Yes 2	□ No	3 Probab	bly 4 thknown
SecKer Vital Records,	been signed by the attending should be detached for use a leted by Physician/M									24a. Was	an autop	sy	24b. Were	autopsy findings
eco	cate has been signated a specific completed									perfe	omed?		comp of dea	able prior to stetion of cause ath?
J & 8	ate he page									1 🗆	Yes 2	No	1□Y	res 2□ No
of Vita	actor, Be	25. Was case referred examiner?		Hospital:				Other		ath (Check only	one)			
10 E	rthis ca tral dire	1 Yes 2 No	·	1 L Ir	npatient 2 🗆	ER/Outpat 28b. Time			4 Nursing F	forme 5 ☐ Resi				
Vision Attending	a funa		5 Pending investigation		of Injury h, Dey Year)	injun	м	i. Injury Work 1 □ Y	? ∕es 2 □ No	200. 2000.20	now injury	Occurre	,	
Division for Attending	al Director: After to the in by the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury - At ho		street, factory,	office		28f. Location (City or To		l Numbe	er or Rural R	oute Number,
Division To the Hospital or Attend	To the Funaral Director: After this cartificate has completally filled in by the funaral director, page 2. Medical Certification: To Be Completed.	29a. Certifier	Certifying Phy	sician: To the l	best of my kno	wledge, de	ath occurred at	the time	e, date and place	and due to the	canco(c)	and man	nner as state	ed.
the Ho	the Funar npletaly fill	one) 2[_ Medicai Exami	Iner: On the ba and mann	sis of examinat	tion and/or	investigation, in	n my op	inion, death occu	irred at the time,	date and	ptace, a	nd due to th	e cause(s)
P P	To to	29b. Signature and titl	e of certifier	1		11	() 29c. I	License	number	U2	29d. Date	signed	(Month, Day	1
	,	30 Nama and address	1110	ompleted same	of death (It-	7 8	o Brint	1) 270	1-	6	12	00	6
	5	BAUCE E)wither	the	mi)	880	0	M	en Blu	1) Parl	Call	1	Md	21234
	State Registrar	31. Date filed (Month,	Day, Year) 2 1 2006	32. Re	egistrar's Signa	ture	. · ·							

ORIGINAL

		4	For State Registrar	State of Mary		artment of H rtificate of			iene 0 0	6	19416
7.4		×	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		'ear	3. Time of Death
	Physicia /Medic		A	lice	J.	Bright		June 1	6,2006		5:20 A M
	Examin	ér	4a. Facility Name (If not institution, give s			4b. City, Town, c		ath	4c. County of		
-2		-	1311 Southwell L 5. Social Security Number 6. Sex		yrs. last birthday)	Bel A		rs. 8. Date of Birth	Harfo		on (State of Foreign
25	Funeral Director			M 2 XF 91	yrs. iasi birtinday) Yrs.	Months Days	Hours Mi	n. (Month, Day,			ce (State or Foreign
	Mids g S		Usual Residence of Decedent	1 21				Feb. 23	,1915	Mary	Ianu
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d	d. Inside City Limits
	a-f el	ctor	Maryland Harf	ord Co.		Вe	1 Air				1 ☐ Yes 2 ☒ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of Wh	at Country	y?
	ath w		1311 Southwell				21014		United		
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itema 23a or 28a-f ehow this Medical Examinar must be natified at	Funeral	Tr. Wallar States	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Black,	White, etc	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	W	hite
Ş	2 hou		15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busi	ness/Indu	stry
212	nin 72 in "nu Medil	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d)	vorking			
7	d with	E O	8 Years		Ho	usewife			Own Ho	ome	
g	be filed within 72 hours after death with the Marylan Ital Hyglene id other than "natural", or Itema 23a or 28a-f show event, the Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, M	faiden Sumame)		
<u>X</u>		9	Roy Hurley					rnice Krie			
Maryland 21215-0036	2 should and Men le marke raumatic		19a. Informant's Name/Relationship (Type					Rural Route Number, Bel Air,			ode) 1014
	of Health of Health litem 27 I	1	Mr. Andrew Bright 20a. Method of Disposition		20b. Place of Dispo		II Lane		Platy at 20c. Location - Ci		
פֿר	Pages nent of h int: If Ite		W☐ Burial 2 ☐ Cremation 3 ☐ R		cemetery, crei	matory or other pla	1			•	
Baltimore,	it. Pi		4 Donation Other (Specify) 21. Sign three Anneal Strvice License	1.11	B	Cemeter Name and Addre		2006	Baltimo	ore,	Maryland
B	permit. Pages Department of I Important: If Ite eny injury or or once.		I heen W	Fall	. D	uda-Ruck 922 Wise	Funeral	l Home of undalk, Ma	Dundalk, ryland	Inc 2122	2'2
ŧ.			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	death. Do not ent	er the mode of dyin	ng, such as cardi	ac or respiratory arre	est,	A	oproximate nterval Between
. 00	Physician		tmmediate Cause (Final disease or condition	Cerch	ral Vas	cular i	Acerdo	1		C	Onset and Death
	/Medical		resulting in death)	Due to (or as a co		CD ((CO					12 - 41(01);
, .	Examiner		Sequentially list conditions.	Hyper	tersion	<u> </u>					20 years
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a co	onsequence of):						-
V	and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	ate be executed thysician and the burial-transit			200 10 (0: 00 0							
687	the the	edical		•							
XO	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p		7			23d. Date of	of delivery	
Ď	0 0	icia	in the past 12 months? 1 ☐ Yes 2 🗹 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		<pre>]Ectopic pregnanc</pre> <pre>] Other (specify) _</pre>	y 		Month	n Da	ay Year
0.	at the de by the a	hys	9 ☐ Unknown	9□ Unknown							
Ś	requires that the wen signed by th hould be detache	by F	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	1	acco use contrib		
ord	requir been si should	ted						1 ₽Ye	s 2□No 3	Probab	oly 4 Unknown
Record	> 11 to	Completed						24a. Was ar autops	/ pric	or to comp	y findings available detion of cause of
<u>~</u>	The law	Co						perform 1 ☐ Yes 2		th? Yes 2	□ No
Viia	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Ott	000	eath (Check only one			
of	Physical direction	7	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ 27. Manger of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatier		4 🗆 Nuising	Home 5 side			
L _O	ding F h. After funer	ion	1 Natural 5 ☐ Pending	(Month, Day Ye	ar) Injury	Wo	rk? Yes 2 □No	28d. Describe no	w injury occurred		
Division of	Attender death	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury building, etc. (S	- At home, farm, str			28f. Location (Str	eet and Number	or Rural F	Route Number,
<u>S</u>	after Dire d in b	Certification:	4 Homicide	building, etc. (S	Specify)	,		City or Town	, State)		
	hours unera		29a. Certifier (Check only 2 Medical Exami	sician: To the best of m	y knowledge, deat	h occurred at the til	me, date and pla	ce, and due to the ca	use(s) and mann	er as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director.	Medicai	29b. Signature and title of certifier	and manner stated		29c. Licens					
	70 Vit	_	2-50. Signature and title of certifier		114.0		6768	25	Od. Date signed (106	
•	•		20 Norman 10	Tolored assess of the i	WAS 23a) (Tuna						
	()		30. Name and address of person who co	uks, mo	456	Allia	ce St	ret Ho	uvede	Grace	2, MD 21072
3	Sta Registi	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	el de		ŧ			

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

2006

JUNE

LOUISE CRAWFORD

State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) June 18, **Physician** Cornell 2006 Thelma Η. 7:50 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Heritage Dundalk Genesis eldercare -If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 19, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2X F Maryland 74 June Director 213-30-5241 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City. Town or Location r than "natural", or iteme 23a or 28a-f ehow the Middeal Examinar must be notified at 1 Yes 2 No Director Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 3440 Liberty Parkway Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If itam 27 ie marked other than "natural; or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Secretary 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Frve Otto Wingate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick A. Cornell Jr. Husband 3440 Liberty Parkway, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) June 21, 20c. Location - City or Town, State 20a. Method of Disposition 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or ance. Sacred Heart Of Jesus Cem. 4 ☐Donation 5 ☐ Other (Specify) 2006 Dundalk, MD. 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 21. Signature of Funeral Service Licensee, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as signed by the attending the detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Live beath 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of deaty Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 20 certificate 1 Yes or Attanding Physician: 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one, Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient Certification: To 1 Inpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18.2006 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perInf, C856, 6/27/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month **Physician** June 19 6:46 p M Dorothy C. Creech /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Months Days Hours Min. April 30, 1948 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 217-50-3577 1 ☐ M 2 🔀 F Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or itsms 23a or 28a-f show other treumstic svent, the Modical Examinar must be notified at Md. Baltimore 1 ☐ Yes 2 🔀 No Towson Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiane. 29 Bellows Court 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ★ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mentat Hygiane. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Chelton Dorothy Causley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Julie Chapline/ Daughter 717 Scottish Isle Dr. Abingdon, Md. 21009 Depertment of Health a important: if item 27 is any injury or other tre once. timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Co. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 6-21-06 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a c instry Distress Syndrone Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse anding physicien and use as the burial-transit the Hospital or Attending Physicisn: The law requires that the death certificate be executed Due to (or as a cons Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate hes been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Tyes 2 No After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 2 Accident 5 Pending 24 hours efter death s Funarei Director: A 1 ☐ Yes 2 ☐ No investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number th (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JUN 2 1 2006 Registrar

		1	For State Registrar	State o	of Marylar		artment of Hortificate of L			eg. No. 2006	19421
	Physicia		Decedent's Name (First, Middle						2. Date of Dea		3. Time of Death
	/Medic	al -	Jeanette Joy						June	18 2006	11:30 a M
7	Examin	er	4a. Facility Name (If not institution Carroll Hospit				4b. City, Town, or West	Location of Death Minster	1	4c. County of Deat	
	Funeral Director		5. Social Security Number 212-40-6179	6. Sex 1 □ M 2 ☐ F	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2		hplace (State or Foreign untry) y Land
			Usual Residence of Decedent		1.0						
laryla	shov	5	10a. State 10b. County Maryland Carro	11		ty, Town or Lo lanches					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the A	28a-I	rect	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?
h with	23a or		5010 Stoney La	ne			21	102		U.S.A.	
:1215-0036 within 72 hours after death with the Maryland	artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "netural", or Items 23a or 28a-f show injury or other treumatic event, the Medical Exarctiver must be notified at	by Fur	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 🗍 No ive		Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
5-0 72 Po	netura	eted	15. Deceden (Specify only highe)	(Give	dent's Usual Occupa	uring most of wor	kina	16b. Kind of Business/	Industry
21215-0036 ad within 72 hours af	han "	Completed	Elementary/Secondary (0-12)	2 ^{College}		life.	DO NOT use retired) USEWife			Homemake	r
CA B	antal Hygie ted other i c event, it	Be	17. Father's Name (First, Middle, Melvin Berger		1				ne (First, Middle, i		-
2 5	alth and Me 27 is mark or treumati	J.	19a. Informant's Name/Relations Michael E. Cheu		· - hus					ter, Md. 2	
altimore,	nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		State	cemetery, crer	esition (Name of matory or other place Park Cem.	· I		20c. Location - City or Woodlawn,	
Balti Permit.	Department of I Importent: If its any injury or o		21. Signature of Funeral Service			32 32	Name and Address 96 Charmi			, Md. 2110	2
Geculed	physician and water street transit the burial-transit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dy to	o (or as a consecutive of consecutiv	number off	an and	when	Shsen.	,	2.mm 4.mm
, P.O. Box 68760, that the death certificate be ex	y the attending iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □Live 4 □ Preç 9 □ Unk		al death 3 death 5 death	Ectopic pregnancy Other (specify)		Gao Did to	23d. Date of del Month	Day Year
rds,		by	Part II. Other significant condition	ons contributing to	death but not res	suiting in the u	nderrying cause give	n in Part I.		bacco use contribute to es 2□No 3□	
Records,	ate has been si page 2 should	Completed							24a. Was a autops perform	y prior to o	topsy findings available completion of cause of
Vital sician: T	certificate rector, pag	Be C	25. Was case referred to medica examiner?			1			ith (Check only on	е)	
of Vita	S P	2	1 Yes 2 No		Inpatient 2 S	ER/Outpatier		4 Iduising H		ence 6 Other (Spec	cify)
	After fune	tlon	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mo	nth, Day Year)	Injury	Work	es 2 □ No	280. Describe III	ow injury occurred	
Division of or Attending	after death. I Director: A d in by the fu	ertification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At h ding, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ıral Route Number,
Hospitel	within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	Examiner: On the	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the	within 2 To the	M	29b. Signature and title of certifie	milde	ota n	10	D25	number YY3	2	9d. Date signed (Monti	200 C
6	U	<u>_</u> 9	30. Name I'd address of prison	who completed car	eton	m 23a) (Type,	Print) Paole Rd	, West	minster	MP 21	157
V	Sta Regist		31. Date filed (Month, Day, Year)	2006	legistrar's Sign	eluro	and I			1	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year :20 Am **Physician** 19, JUNE 2006 RECTINA CURBEAN L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 1814 MARYLAND AVENUE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. APRIL 25, 1966 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 M 2 XF Director 40 MD 212-78-4843 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County **ehow** r than "naturel", or items 23a or 28a-f ehovine Medical Expriment by notified at 1X Yes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 1814 MARYLAND AVENUE IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within : lith and Mental Hygiane. 27 ie marked other than "! r treumatic event, the Mas College (1-4or 5+) Elementary/Secondary (0-12) 12 DATA ENTRY BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 is marked 4 any injury or other treumatic events once. ALBERTA COOPER NATHANIEL CURBEAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALBERTA CURBEAN/MOTHER 422 CHESTNUT ST. BALTIMORE, MARYLAND 21217 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 6-26-06 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) liver **Physician** nd Stage /Medical Due to (or as a consequence of Examiner hera his Due to (o as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine siclan and burial-transit certificate be executed Due to (or as a consequence of) Box 68760, attanding physiclan for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. this certificate has been signed by the ral director, page 2 should be detached 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 71D2 1 Yes 2 No 3 Probably 4 Unknown pieted 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Com 1 Yes 2 No tal or Attending Physician: T is after death.

I Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of n Natural 2 ☐ Accident Injury 5 Pending NIA 1 Yes 2 No investigation NIA 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide NIA within 24 hours a
To the Funerel I
completely filled Hospital 29a. Certifier 11% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monument St, Balhmore 1830 ORS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUN 2 1 2006

,			For		State of M	arylan		artment of			ental Hy	/giene	2006	191.2
1			1 - State Registrar				Ce	ertificate of	Death			Reg. No.		J 1-9 Cm.
Г	Physic	ian	Decedent's Name (1)	63 1				1	2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi	cal	Hayd			Cale	over				6	17	2006	
1	Exami	ner	4a. Facility Name (If n	- 1)	1 Medi	1.0	Cal	4b. City, Town,	0 .		ID	4c. (County of Death	0-1
	Funeral	Petil L	5. Social Security Num	her 6 Se	Y 7 Ac		last birthday) If Under 1 Year	4	24 Hrs. F	3. Date of Bi	rth	Aune /	place (State or Fornia
В	Director		212-60-16	00	_̂м 2 т Г	83	Yrs.	Months Days	Hours	Min.	(Month, D	, Year) , 192	2 Cub	place (State or Foreig intry)
	p ,		Usual Residence of D			_						, 1)2	2 Cub	<u>a</u>
	tarylan show	2		0b. County			y, Town or t	ocation.						10d. Inside City Limits 1 ☐ Yes 2 No.
	the M	ecto	MD 10e. Street and Numb	Anne Aru	ndel	Ar	nold	1 - 2 - 2 - 2						
	with a or	2						10f. Zip Code	•				en of What Cou	intry?
	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Iteme 23a or 28e-f show event, the Medical Exertine must be notified at	Funeral Director	624 Basi	n Way	12. Was Decedent	Ever in U.	S. 13	Was Decedent of		gin? (Speci	fy Ves or N	US.	A 4. Race - Ameri	ican Indian
9	or Iter	Ξ	1 Never Married	2 Married	Armed Forces? 1 ☐ Yes 2 ☐ 1			Was Decedent of If Yes, specify Cut			can, etc.)		Black, White,	, etc.
21215-0036	ral', c	by	3 ☐ Widowed 4		If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ No	Specify:	whit	е		Specify: whi	te
5-0	72 h	Completed	(Specify	5. Decedent's Edu	cation le completed)		16a. Dec	edent's Usual Occu	ipation	t of working	,	16b. Kin	d of Business/Ir	ndustry
121	within ene. than "	mpi	Elementary/Second		College (1-4or 5	5+)	life.	DO NOT use retire	ed)	or working				
7	filed v Hygie Ither t		17. Father's Name (Fin	rst Middle Last)	5+		Soci	al Worker					spital	
and	lid be 1 lental I ked of	Be C	Julito Ca								^{First, Middle} erovai		iumame)	
Maryland	no de M	2	19a. Informant's Name		rpe. Print)		19b. Mai	ing Address (Stree	1				Town State 7	o Cordo)
	re L	İ	Orlando G				1	Basin Way						o code)
ē,	of Healt of Healt fitem 2		20a. Method of Dispos	sition		20b. Pl	ace of Disn	osition (Name of matory or other pla		Dat			ation - City or To	own, State
E	Pages nent of I		1 ☐ Burial 2 ☐ 0 4 ☐ Donation 5		Removal from State		_	ematory		une 2	0, 06	Ba1	timore,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	ral Service Lice	e									
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P			23a. Part 1. Enter the shock, or heart fa	disease, or compl ailure. List only o	ications that caused ne cause on each	the death	. Do not er	ter the mode of dyi	ing, such as o	cardiac or r	espiratory a	rrest,		Approximate Interval Between
-	Physician		Immediate Cause (Fir disease or condition		July	%_ C >	~ e &		5 (Quad					Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):							decay
146	LAGITITICI		Sequentially list condit	tions,)	Parison or	Control of							
	ted	Examiner	dany, leading to minicause. Enter Underlyi Cause (Disease or inju	ng Inv	Due to (unas	a sonsequ	unda of).							
	cate be executed physicien and the burial-transit	xar	that initiated events resulting in death) Las		Due to (or as a	a consequ	ence of);							
38760,	sicier sicier	dicai E												
•														
Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pr	egnant 2	3c. If yes, outcome		-,	75-4				23	d. Date of delive	ery
œ.	0 0 0	sicia	in the past 12 mo 1 ☐ Yes 2 🗷 N		1 □Live birth 4 □ Pregnant at 9 □ Unknown			□Ectopic pregnanc □ Other (specify) _	У				Month	Day Year
о <u>.</u>	The law requires that the de ate has been signed by the a page 2 should be detached i	Phy	9 □Unknown											
	w requires tha s been signed I should be det	þ	Part II. Other significa	nt conditions cor	tributing to death bu	it not resul	Iting in the u	nderlying cause giv	ven in Part I.		23e. Did to	obacco use	ocontribute to the	ne cause of death?
orc	requi	Completed	Alshai	C 45	1200	vee:	Sie				1 🗆 ነ	/es 2 □	No 3 ☐ Prob	ably 4 Unknown
Sec.	has b	nple				-					24a. Was autop	sy	24b. Were auto	psy findings available inpletion of cause of
Vital Records,	ysician; The l is certificate ha director, page										perfo	rmed?	death?	2X No
<u>=</u>	Physician; r this certifica ral director, p	Be	25. Was case referred examiner?	1.7-	ospital:		_	! 0#	200		check only o			
o	를 등교	5	1 ☐ Yes No. 27. Manner of Death		28a. Date of Injur		R/Outpatie 28b. Time o		4 🗆 Nur				Other (Specify	/)
Division of	th. : Afte	it or	1 XNatural 5 2 ☐ Accident	Pending investigation	(Month, Day	Year)	Injury	Wor	rk? Yes 2 □ N		. Describe h	iow injury t	occurred	
<u>S</u>	Atter r dea ector by the	Fice	3 Suicide	Could not be	28e. Place of Inju	ry · At hon	ne, farm, st				Location (S	Street and I	Number or Rura	I Route Number
	s afte	Certification:	4 Homicide	331311111733	building, etc	. (Specify)		,, ,,			City or Tou	m, State)	Torribation of Profession	rriodio ramber,
	ospit hour unere ly fille		29a. Certifier 12	Certifying Phys	ician: To the best of	f my know	rledge, deat	occurred at the tir	me, date and	place, and	due to the	cause(s) ar	nd manner as st	ated.
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ledical	one)	JWedicar Examir	ner: On the basis of and manner stat	examman	on and/or in	vestigation, in my o	ppinion, death	occurred a	at the time, o	date and pl	ace, and due to	the cause(s)
	with To T	Σ	29b. Signature and title	of certifier	2. (29c. Licens	e number			29d. Date s	signed (Month, L	Day, Year)
•	5			3	M			Dog	06178	3		6	-17-8	16
5			30. Name and address	o person who co	mpleted cause of de	ath (Item 2	23a) (Type	Print	k	15.4.20.	2.	MI) 7:1	101
	10/85/20		Change 31. Date filed (Month, L	Day Year!	-		ical	IKNY	(son	with.	ws,		-17-0 > 21h	701
1	Sta Registr		J. Balo med (Magnit, C	JN 2 1 20	32. Po istra	i s signatu	and and	E 10						
DHN	MH 17 Rev 1/20				AS DELA	as S	r fg							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6-13 PM DOLSEY KOBERT Louis 2006 JUNE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE Jenue **JOON** If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours 1**X**M 2□ F 1-62-681. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 MNo IYes, Give Year or Dates: 1003 JENILLE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Bla 1 Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) itanance 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Torda 70 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, PTM INC 20b. Place of Disposition cemetery, crematory Method of Disposition Disposition Removal from State 20. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Balto 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATITY DILATED disease or condition resulting in death) Due to (or as a consequence of):

Examiner DIVISION of Vital Records, P.O. Box 68760, use as the burial-transit sate has been signed by the attending physicien and page 2 should be detached for use as the buriat-trar within 24 hours after deeth.

To the Funeral Director: After this certific completely filled in by the funeral director.

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

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Funeral

Director

with the Maryland

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28e-f ahow any injury or other traumatic avent, the Medical Examinat must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence C. Due to (or as a consequence d.	to R	FNAL T) (S (FAS)		
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 4 Pregnant at time of death 9 Unknown				23d. Date of deliver Month	y Day Year
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting	g in the underlying o	cause given in Part I.	23e. Did tobacco	ouse contribute to the	e cause of death?
Complet					24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Be	25. Was case referred to medical examiner?			26. Place of Deat	th (Check only one)		
To E	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 D	OA Other: 4 Nursing Ho	ome 5 Residence	6 ☐Other (Specify)	
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 Yes 2 No	28d. Describe how inj		
Certification:	3 Suicide 6 Could not b		, farm, street, factor	y, office	28f. Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
Medical (nysicien: To the best of my knowled miner: On the basis of examination and manner stated.					
ž	29b. Signature and title of certifier		29	c. License number	29d. D	ate signed (Month, D	Pay. Year)
	1 lula	men MT		DI812	0 Ju	NE 1916	- 2006

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ROSEMAKIE

RAVEN BLUD BALT 3601 LOCH 32. Registrar's Signature park

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

06-04265 Katiria Delacruz

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg No. 2006 101.
Physician/ Medical Examiner	
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Death Baltimore City 4c. County of Death Baltimore City
Funeral Director	5. Social Security Number 119-66-6089 6. Sex 17. Age (In yrs. last birthday) 119-66-6089 1 Months Days Hours Min. 08/22/1981 Foreign Brooklyn Country) NY
re Maryland or 28a-f show any fied at once.	Usual Residence of Decedent 10a. State
ith the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5118 Wright Avenue 21205 USA
≥ E 3 %	Specify: Villa Yes 2 No specify: Specify: Will Ce
Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death of Health and Mental Hygiene. If item 27 is marked other than "natural", or iten her traumatic event, the Medical Examiner must To Be Completed by Fune	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) Data Entry 16b. Kind of Business/Industry Anacomp, Inc
1215-0036 Id be filed within 7 fental Hygiene. narked other than verent, the Medical	Pedro Jose Rodriguez Nilsa Figueroa
imore, MD 21 Pages I and 2 should ment of Health and Me rant: If item 27 is ma or other traumatic or	Victor De La Cruz S118 Wright Avenue, Baltimore, MD 21205
Baltimore, MD 21 permit. Pages I and 2 should Opparment of Health and Me Important: If item 27 is ma injury or other traumatic or	Lutheran All Faith 6/24/06 Middle Village, NY
Balt Balt Balt Balt Balt Balt Balt Balt	Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 233 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resurgitory arrest, shock or heart Approximate Interval
/Medical Sxaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Death Death Death
ated d ansit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Exi	UNPENDED X AMENDED item#1, perME, g857,7/7/06 TT 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
O. Box 687 ut the death certification by the attending ached for use as the physician.	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
ords, P.C	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Peritification: To Be Completed by P	autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital I Physician: er this certifi ral director, To Be C	25. Was case referred to medical examiner? 1 V Yes 2 No 128. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Division of N ppital or Attending Ph. rours after death. Iffilled in by the funeral Certification: T.	1 Natural 5 Pending Investigation Power Investigation Power Investigation Investigation Power Investigation Inves
Divis Hospital or A 24 hours after Funeral Dire tely filled in b	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Multi-Family Apt. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1405 Anglesea Street Apt. 2-A, Baltimore, Md. 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.
To the Hos within 24 hu To the Fun Completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)
5	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	JUN 2, 1 2006 Week H. Apollo
DHMH 17 Rev 1/2001	ORIGINAL

			1 - For Stete Registrer	State of Maryla	nd / Depa		Health and	Mental Hyg	piene _{eg. No.} 2006	5 19427
	Physic /Medi		Decedent's Name (First, Middle, Lag John Francis Do					2. Date of Dea Month	th Day Yea	
8 -	Exami		4a. Facility Name (If not institution, given Franklin Squeen S. Social Security Number 6.5	ire Hospit		Rosed		h	4c. County of De Baltin	nore
	Funeral Director			1 ☑ M 2 □ F	s. last birthday) 9 Yrs.	If Under 1 Year Months Day		(Month, Day,		irthptace (State or Foreign Country) aryland
	Marylan a-f show	ctor	MD Baltin		Balti					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the Marylan 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Number 4405 Ebenezer Ro	ad		10f. Zip Code	.236	1	0g. Citizen of What (Country?
980	or Items	b	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No the Yes, Give Year or Dates: 144		Vas Decedent of Yes, specify Cu ☐ Yes 2∏ No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:	
1215-0		Completed	15. Decedent's E (Specify only highest gri	ade completed) College (1-4or 5+)	(Give I		e during most of wor ed)	king	16b. Kind of Busines	
Maryland 21215-0036	e filed al Hygi other vent, I	To Be Co	9 17. Father's Name (First, Middle, Last Robert James Doy		constr	uction		ne (First, Middle, M	Maiden Surname)	orks
Mary	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatice		19a. Informant's Name/Relationship (Patricia Doyle/s	**	19b. Maitin 4405	Address (Stree Ebeneze	et and Number or Ru	ral Route Number,	City or Town, State, MD 21236	Zip Code)
Baltimore,	Pages 1 ament of He ment of He ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ※ Donation 5 ☐ Other (Specific Content of the Conten	Removal from State	Place of Dispos cemetery, crem	ition (Name of atory or other pl	ace)	Date	20c. Location - City o	r Town, State
Balt	permit. Page Department Important: It eny Injury o		21. Signature of Ronald Service Licer Ronald Service Licer	Videl	Ba	ltimore,	MD 2120	1	Baltimore	Street
68760,	Physician /Medical Examiner be executed but sician and physician and physician and sician site of the physician and physician an	dicai Examiner	shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading or immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0 .	quence of):		prrhag			Approximate Interval Between Onset and Death WCC
P.O. Box 6	ath certif attending for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	eldeath 3⊟E	Ectopic pregnand Other (specify)	ey		23d. Date of de Month	olivery Day Year
Records, P	w requires that the de been signed by the should be detached	led by P	Part II. Other significant conditions of Preumonia	ontributing to death but not res	sulting in the und	derlying cause g	ven in Part I.	23e. Did tob	. /	o the cause of death?
Il Reco	> 4	Comple	Coronary Arl	ery Disec	ose			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
f Vita	nysician nis certifi i director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospitat: 1 XInpatient 2	ER/Outpatient	3□ DOA Ot		h Check only one		ecufy)
Division of Vital	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of eath Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury			28d. Describe how	w injury occurred	
Divi	pital or A	Certif	4 Homicide determined	building, etc. (Speci	ry) 			City or Town,		
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	one) 72 Medical Exam	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or inve	stigation, in my	opinion, death occur	and due to the cau	use(s) and manner as te and place, and due	s stated. If to the cause(s)
	To To		29b. Signature and title of certifier	tale Ms - Me	ne-f plicates		57721	(d. Date signed (Mont 0/13/06	
	3		30. Name and address of person who of DR Laura Steele	2 9000 Frank	lin 590	vare Dr	ive Bal	timore	Maryland	1 21237
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 1 200	32. Registrar's Signa	ature	(h.)				

State of Maryland / Department of Health and Mental Hygiene 2 11 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Thomas DePetris May 27. 7:45 PM M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Oeath 6511 Loch Hill Road Baltimore <u>Baltimore</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 MD 1 MM 2 □ F Director 220-20-2814 78 May 28 1927 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show rai', or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits Director Baltimore Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 6511 Loch Hill Road 21239 USA Pages 1 and 2 should be filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1XI Yes 2 N1 945-If Yes, Give Year or Dates: 1966 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No δ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 1966 d Mental Hygiene. marked other than "natura matic svant, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) telephone company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked or traumatic svi Joseph Nicholas DePetris 2 Lucille Ann Marchioni of Health and N Item 27 is man other trauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeane DePetris/spouse 6511 Loch Hill Road Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10 = 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 X Donation 5 □ Other (Specify) 21. Signal woof Funeral Nice Licensee de North de S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erelorovaru /Medical Examiner 100 Sa unitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery ŏ 3 Ectopic pregnancy in the past 12 months? signed by the at d be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 3 Probably 4 □Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 25 No ů 1 Yes 3□ DQA 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. € ☐ Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) ne and address of person MY 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Η. 15 /Medical June 2006 10:00a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 421 BRESLIN RD. JOPPA HARFORD CO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 M 2 X F Director 219-10-2804 YES Virginia May 24, 1924 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No HARFORD JOPPA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Iteme 23a 421 BRESLIN RD. 21085 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ॐ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No ò Specify: 3 ₩idowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th RECEPTIONIST/MEDICAL ASSIST. HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumane, Be SAMUEL A. HAYNES MINNIE MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY BANTNER/DAUGHTER 421 BRESLIN RD. JOPPA, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens | 06-19-2006 | Belair, MD 21. Signature of Furral Service Licensee 22. Name and Address of Facility William C. Brown Comm. Funeral Home-Harford P.A. Melvalu 321 S. Philadelphia Blvd. Aberdeen, MD 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myo cardial inferction Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oronan. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physician and use as the burial-transit ightete Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 ₽No 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after deeth. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036715 6-16-06 - MV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif H. Osman 520 Upper Chesapeake Dr. Suite 211 Bel Air, MD 21014 31. Date filed (Month, Day, JUN 2 1 2 32. Registrate Signat State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 9:15 🕅 Deborah A. Drasal-Labrador June 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 208 Golden Crown Way Pasadena Anne Arundel Co. | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Sept. 20, 1966 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Maryland 39 215-88-1386 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f ehow ury or other traumatic event, the M-cical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nal Hygiene. Id other than "natural", or items 23s or 28s-f ehov event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 208 Golden Crown Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cash Office Giant Food Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary С. Day J. Drasal Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 208 Golden Crown Way, Pasadena, Maryland 21122 (Husband) Jimmie Labrador 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. Glen Burnie, Maryland Glen Haven Mem. Park | 06-20-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral-Service Lice McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 nul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** goeshe /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): sicien and (?) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) cete hes been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed? 2/2KN0 1 ☐ Yes 25 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After To the Hospital or Automore, within 24 hours effer death.

To the Funerel Director; After the funeral in by the fur 1. Natural 5 Pending 2 ☐ Accident investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License numbe V death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 1 Registrar

			For	State of Maryla	-			Mental Hy	giene	. 101.21
			1 - Stete Registrar		Cei	rtificate of l	Death	F	Reg. No.	13431
ı	Physici	an	Decedent's Name (First, Middle, Last)					Date of Dea Month	ath Day Year	3. Time of Death
	/Medi	al	Lucille Del	eon				6	-16 06	
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	0		4c. County of De	ath I I
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	Funeral Director			IM 200 F 75	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day	- 1927 E	inthplace (State or Foreign Country) Puerto Rico
	pc _		Usual Residence of Decedent							
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Maryland 21215-0036	should and Men amarke urnatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street a			r, City or Town, State,	Zip Code)
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Baltimore,	Depentr Depentr Imports eny inju		21. Signature of Funeral Service License		$\overset{22}{\mathrm{D}}$	Name and Address	s of Facility Funeral	Home & C	rematory,	P.A.
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E			shock, or heart failure. List only one	e cause on each line.	atri. Do not ente	er the mode of dying	g, such as cardia	c or respiratory ari	est,	Approximate Interval Between Onset and Death
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Division of Vital	Phys ral dii	5	1 ☐ Yes 2 ₹ No 27. Manner of Death	1 X Inpatient 2L	ER/Outpatien 28b. Time of	t 3☐ DOA Othe	4 Nursing r		ence 6 Other (Specow injury occurred	ecify)
o	ding th. After	tol	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	es 2 □ No	200. Describe III	ow injury occurred	
<u> S</u>	f or Attending efter death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At	nome, farm, stre				reet and Number or R	lural Route Number,
Ö	s efte	Certification:	4 Hornicide	building, etc. (Spec	ify)			City or Town	n, State)	
	To the Hospitel or Attending Physicien: The law within 24 bours effected all. To the Funeral Director Atler this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only 2 Medical Examin	ician: To the best of my kr	owledge, death	occurred at the tim	e, date and place	a, and due to the co	ause(s) and manner a	s stated.
	within 24	Medi	0.107	and manner stated.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 04:45 AN DESYATNIKOVA 2006 /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sirai Hospitel of Baltmore City N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Months 1□M 2QF 214-51-9650 79 06/29/1926 Director LIKRAINE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.
Item 27 is marked other than "natural", or itema 23a or 28s-1 show other traumatic event, the Medical Expiritment was the invitilled at 1√2 Yes 2 No MD N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3615 FORDS LANE #506 21215 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES RFTAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LEB PRITICKEN LAKEA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
important: If item 27 is
any injury or other trau LEV DESYATNIKOV / SON #303-0WINGS MILLS, MD 21
Date 20c. Location - City or Town, State 190 OWINGS GATE RD. MD 21117 20a. Method of Disposition

1 🖸 Burial 2 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CONG 06/20/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** doys Jepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Billary obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an discore. autopsy 250 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 ☐ Yes 2 No 2 ER/Outpatient 1 Mnpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

7 State

Desyatrikova

ather known as

Registrar

DHMH 17 Rev 1/2001

JUN 2 1 2006

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated

MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nelson

Sinai

29c. License number

29d. Date signed (Month, Day, Year)

2006

			1 - Stata Amend #19a Per	tate of Mar Inf G858	yland / De 8/18/0	epartmer	nt of H	lealth and Death	Mental Hy	giene Reg. No.	006	19434
			Decedent's Name (First, Middle, Last)	-					2. Date of De	eath		3. Time of Death
	Physici /Medio		Phirouz Ebrahimi						June	10 Day	2006	1:40 PMM
	Examin		4a. Facility Name (If not institution, give stre	,		4b. City		Location of De	ath	4c. Co	ounty of Death	
			Atlantic General H					rlin	-		Worces	
	Funeral Director		5. Social Security Number 406-17-1971 Usual Residence of Decedent	2 ☐ F	In yrs. last birtho	Months	Days	If Under 24 Hi Hours Mi		$\frac{\text{rth}}{\text{a}y, Y \theta \text{a}r}$ $\frac{192}{4, 192}$	Count	ace (State or Foreign try) unk
	yland yland		10a. State 10b. County	1	Oc. City, Town o	r Location					10	Od. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ent. The Madical Examitter must be multified at	by Funeral Director	MD Worcester		Ocean	City						1 ☐ Yes 2√ No
	vith th	Dire	10e. Street and Number			10f. Zi	p Code			10g. Citizer	of What Count	ry?
	eath v	eral	304 140th Street	Was Decedent Eve	or in II C	12 Was Dass		1842	/C	- 14	USA	
(0	r Item drien	Fun		Amed Forces? 1 Yes 2 XNo	91 III U.S.	If Yes, spe	ecify Cuba	n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	0- 14.	Race - America Black, White, e	
036	rel', o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2∭ No	Specify:		Sp	pecify: Whi	te
5-0	72 hours naturel', dical Ex.	etec	15. Decedent's Educati (Specify only highest grade co	on empleted)	(0	ecedent's Usu Give kind of wo	ork done a	luring most of w	orking	16b. Kind	of Business/Ind	ustry
121	be filed within 72 ho ital Hygiene. id other than "natur event, Iby M. C.F.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lii	ъ. DO NOT (1aw)			1egal	
d 2	Hygi Other	Be Co	17. Father's Name (First, Middle, Last)	0		Taw	701	18. Mother's N	ame (First, Middle	, Maiden Su		
<u>la</u> n	uld be Aental rked o tic eve	To B	Ali Ebrahami					Mah	nbobe Kar	imi		
Maryland 21215-0036	s 1 and 2 should be if Health and Mental item 27 is marked o other treumatic eve		19a Informant's Name/Relationship (Type Malihe Salamolfani)	Print) Spouse	19b. M	ailing Addres	s (Street a	nd Number or f	Rural Route Numb	er, City or To	own, State, Zip (Code)
	l and fealth im 27 her tr	1 7	Malihe Abrahimi/sp	ous e				reet Oc	ean City			
סר	ages 1 nt of H :: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem		20b. Place of Di cemetery,	sposition (Na crematory or (me of other place	9)	Date	20c. Locat	ion - City or Tow	vn, State
Baltimore,	permit, Pages 1 Department of H Importent: If ite any injury or ot		 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Eneral Activities Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.1 a La Price Licensee 10.	de, Direc	tor	23 Name	nd Addres	e of Facility Boa	ard 655 W	J. Bal	timore S	Street
	<u> </u>		23a. Part1. Enter the disease, or complicati	1 sale		Balti			201	·		
	-		shock, or heart failure. List only one c	ause on each line.		10.00				rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cabse (Final disease or con filon resulting in death)	Due to (or as a c	ustatic		eno	carcir	ioma			
100	Examiner			Kidi		incer						
040	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Dus to (or as a c	till a uence of).							
S. S.	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c		o (and	Ca	encor				
4/172	be ex	al E		D09 10 (0) 43 4 0	onseque - e or).							
1/5/2	tificate ig phys as the	edicai	d. =									
6 % Box	death certiff e attending id for use as	Physician/Me	230. Was decedent program	If yes, outcome of p 1 ☐ Live birth 2 ☐		3 □Ectopic p	rooman av			23d.	Date of delivery	/
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971 Rec	The lav	Completed	Corolling /11 /org	12 60-00					autop perfo	rmed?	prior to comp death?	sy findings available pletion of cause of
- 6.	ien: T	Be C	25. Was case referred to medical					26. Place of De	1 ☐ Yes		1 ☐ Yes 2	∐ No
01 C	Physicien: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 ☐ No Hosp	ital: 1 Impatient	2 ER/Outpa	tient 3 DC	Othe	r. 4 🗆 Nursing	Home 5 Resid	dence 6	Other (Specify)	74 - Nii - #4
	ing P		27. Mann Death 2 1 atural 5 ☐ Pending	8a. Date of Injury (Month, Day Ye	ear) 28b. Time Injur		28c. Injury Work	at ?	28d. Describe h			
higadz 466- Division	Attending r death. ector: After	icati	2 Accident investigation 3 Suicide 6 Could not be	Go. Blood of Injury	At home form	M		es 2 □ No	204	24		
biv Div	after Direct	Certification:	4 Homicide determined	8e. Place of Injury building, etc. (S	Specify)	street, factor	y, office		28f. Location (S City or Tox	vn, State)	amber or Hural F	Houte Number,
_	Hospitel 14 hours a Funerel I tely filled		29a. Certifier 1 Certifying Physicis	n: To the best of m	ny knowledge, de	eath occurred	at the time	e, date and place	e, and due to the	cause(s) and	I manner as stat	ed.
	the the	Medical	one)	On the basis of exa and manner stated	amination and/or	investigation	, in my opi	inion, death occ	urred at the time, o	date and pla	ce, and due to th	ne cause(s)
	To To	4	29b. Signature and title of certifier	. hin			D56				gned (Month, Da	
			30. Name and add s of person who compl	etal cause of darm	h /ltem 22ct (To-	Deint)	レンじ	מוכ	1	UJUN	12006	
			Gregory W. Stain	inas, M.	D 973	3 Hea	Mar	vay Dr	ive Ran	lin. N	10 218	11
2	Sta	A	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Bank	3	1	- 1000	····) ·	/	1
	Registra	ar	JUN 2 1 2036	fr. Stephen	2 200	par de			ive Ber	_		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert S. Emmons June 17,200611:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F Yrs. Director 70 191-26-8310 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28s-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Florida Volusia Port Orange 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5569 Lancewood Drive items 23a 32127 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter may injury or other traumatic event, the Medical Examinations, page. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2₺No Specity: White Specify: White 3 ☐ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Motor Cycles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell Emmons 2 Frances Stratton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 5th Ave. Brooklyn Park, Maryland 21225 James Fischer - Guardian POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 Noremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory June 20, 06 Baltimore, Maryland 21. Signature of Funeral Service Licensi Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 23a. Part1. Exter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final elmororde Physician disease or condition resulting in death) seeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physicien and use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 5 Pending investigation death. I Director: A d in by the ft 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dea To the Funerel Directo \completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Fune 19,2006 D-40521 MOJPITAL DRIVE LITE 208 325 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and Me 1- State Registrar Certificate of Death	ntal Hygier	4000	19436
	Physici /Medic		Victoria Francis	2. Date of Death Month	Day Year 5 2006	3. Time of Death 3:00P M
_	Funeral	er		I. Date of Birth (Mpnth, Day, Yea	4c. County of Death N 9. Birthn County A A A A B County A B County A County A B County A County A County A County Coun	place (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	01 03 19		nidad 10d. Inside City Limits
	or 28a-f s	Director	MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code	10g. (Citizen of What Cour	1 Tyes 2 No
36	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural" or items 23a or 28a-f show of other than "natural" or items 23a or 28a-f show event, the Medical Examinar must be mailified at	by Funeral Director	8826 Blairwood Court Apt. A1 21236 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Dolo If Yes, Give 1 Yes, Specify Cuban, Mexican, Puerto Rice 1 Yes 2 Dolo If Yes, Give 1 Year or Dates:	ty Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: 3	
21215-003	- 71	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AVAGE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Do MLStic	16b.	Kind of Business/In	-
Maryland	should be filed withir nd Mental Hygiene. marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (F Theodora	a Leota	aud	
altimore, Mar	1 and 2: Health a tem 27 Is		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F 8826 Bluir wood Cown 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural F 8826 Bluir wood Cown 20b. Place of Disposition (Name of cemetery, crematory or other place) 0 ALI AWN Cemetery 06 21	Apt A	y or Town, State, Zip Location - City or To paltimo	Mb 2123
Baltir	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee , 22. Name, and Address Lacility		Senjios Mb 212	
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to the same consequence of:	espiratory arrest,		Approximate Interval Batween Onset and Death
760, 🖄		Ical Examiner	Sequentially list conditions, if any, leading to immediate auto. Extra tribution that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to th 2 ☑No 3 ☐ Prob	ne cause of death?
Il Records,		Completed		24a. Was an autopsy performed?	prior to condeath?	psy findings available mpletion of cause of
VIII 3	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital: Description 200 10			
Division of Vital	ding Ph J. After th funeral	ation: To	1 Inpatient 2 ENOutpatient 3 DOA 4 Nursing Home	5 ☐ Residence d. Describe how in	6	y)
Divis	ital or Attendurs after deatlurs after deatlurel Director:	Certification:	4 Homicide building, etc. (Specify)	City or Town, Sta		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date a	s) and manner as st nd place, and due to	tated. the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month,	Day, Year)
	3		30. Name and address of person who copleted caus of eath (Item 23a) (Type, Print) W.A. Riley GBMC 6701 N. Charles	(1. Bo)	ne 16,0	21200
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 1 2006 32. Resistrar's Signature	-7.	_	

			FOI	partment of Health and Mertificate of Death		ene g. No. 2006	19438
	o Dhuaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Thomas Ludwell Fletcher		June	17 200	2:05 A M
,	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			12700 Silverbirch Lane	Laurel		Prince (
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 579−10−6797 12 M 2 □ F 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign buntry)
	Director	-	Usual Residence of Decedent		Jan. 16	, 1922 Was	hington, DC
	land ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary 	tor	MD Prince George's Laurel				1 ☐ Yes 2 🕱 No
	r 28a	Director	10e. Street and Number	101. Zip Code	10	g. Citizen of What Co	ountry?
	h with	D D	12700 Silverbirch Lane	20708		USA	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Ame Black, Whit	
ဖွ	after or its	E/	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 1943 −	1 ☐ Yes 2 ☒ No Specify:	7710471, 010.7	Specify: Wh	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow ha Madisal Examere meat be collified a	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946				
7	natu	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing	6b. Kind of Business/	Industry
12	withir then then	E D	Elementary/Secondary (0-12) Cotlege (1-4or 5+)	ce President		Bank	
2	Hygid ther	ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
au	d be ental	To Be	Charles William Fletcher	Annie E	lizabeth	Lee	
Maryland	shoul mari	F		ailing Address (Street and Number or Run			Zip Code)
Š	nd 2 aith a 27 is		Ruth Ohler Fletcher/Wife 127	700 Silverbirch Lan	e. Laure	L. MD 207	08
ē,	f Her frem tem othe		20a. Method of Disposition 20b. Place of Dis			0c. Location - City or	
Ë	Page nent c		1 Burial 2 AlGremation 3 Hemoval from State		/2006	Odenton, M	ID
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show emportant: if Item 27 is marked other than "naturel; or items 23a or 28a-f show empiring or other traumatic event, the Marical Examinin must be notified at once.		21. Ingnature of Funeral Service Licensee	22. Name and Address of Facility DO	naldson I	Funeral Ho	me, P.A.
0	88 = 58		January DON MO1103	313 Talbott Avenue	, Laurel	MD 2070	7
H			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, of heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician			Colon Cancer			Onset and Death 1 year
1.8	/Medical Examiner		resulting in death) Due to (or as a consequence of):				_
S	LAdimine		Sequentially list conditions, Due to for as a consequence of				
s.V	ed isit	lne	rayly leading to immediate cause. Enter Underlying Cause (Disease or injury				
4	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
3760,	ate be executed hysician and the burial-transit	calE					
687	ficate p phy: s the		0.				
Вох	death certificat e attending phy id for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	0.000		23d. Date of del	ivery
	0 00 0	icla	1 Ves 2 No 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (<i>specify</i>)		Month	Day Year
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S, F	gned be de	by	Part II, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
bro	equir en si ould				1 Tes	2 24 No 3 □ Pr	obably 4 Unknown
ec	lawr as be	ple			24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
Vital Record		Completed			penformé 1 ⊟ Yes 22	ed? death? ☐ No 1 ☐ Yes	2 X No
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		h (Check only one)	
of	Physician: this certific ral director.	۴	1 Tes 22 No 1 Inpatient 2 EH/Outpa			ce 6 Other (Spe	cify)
n		lo	1X Natural 5 ☐ Pending (Month, Day Year) Injur		28d. Describe how	v injury occurred	
isi	Attending r death.	fical	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Stre	eet and Number or Ru	ural Route Number.
Division	after Dire	Certification;	4 Homicide determined building, etc. (Specity)		City or Town,		,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or				
	the Hin 24 the Fi	ledical	one) and manner stated.				
	To To To	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
•			Murac Johnson	MD15901		June 19,	2006
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type Michael Grady, 4201 Cathedral Aver		D.C.		
	St	ate	24 Date filed (Month Day Veer) 22 Beginters's Cignature				
15	Regist		JUN 2 1 2006	parke			

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			1 - For State Registrar		aryland / De <i>C</i>	partmei ertifica				lental Hy	giene Rag. No.	006	19	439
*	Physici	an	1. Decedent's Name (First, Middle, Last)		. 2					2. Date of De Month	Day	Year		of Death
30	/Medi	cal	4a. Facility Name (If not institution, give s		V	4h Cih	Tour	r Location o	of Dooth	JUNE	19	2006	17	MAC
	Examir	ner	Good Samaritan Hospit				imore	r Location o	or Death			inty of Death Limore (
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthda	ay) If Unde	er 1 Year	ff Under	24 Hrs.	8. Date of Bir	dh			te or Foreign
核	Director		1000 10 037 1	² x F 85	Yrs	Months	Days	Hours	Min.	February	7 1921	Detro	Sit, Mic	higan
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d foeida	City Limits
	f sho	ō	Maryland Baltimore C	itv	Baltimore									es 2 No
	r 28a	rec	10e. Street and Number	,		10f. Zi	p Code				10g. Citizen	of What Cou	intry?	
	be filed within 72 hours after death with the Maryland nat Hygiene. id other then "natural", or items 23a or 28a-f show event, the Medical Exactions chall be multiped at	Funeral Director	6100 Everall Avenue			212	06				USA			
	ems.	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Dece	edent of Hi	ispanic Origin, Mexican	gin? (Spe	crfy Yes or No Rican, etc.)	o- 14. I	Race - Amer Bfack, White		,
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💢 ! If Yes, Give Year or Dates:	No	1 🗆 Yes		Specify:		, ,		ecity: Whit		
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Division	ne Hospitel or Attendi 124 hours after death. The Funerel Director: A pletely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factor	y, office		2	8f. Location (S City or Tox	Street and Nu. wn, State)	mber or Rura	al Route Nu	ım <i>ber</i> ,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edicai	29a. Certifier 1 Cartifying Phys (Check only one) 2 Medical Examin	ician: To the best of ter: On the basis of and manner sta	examination and/or	ath occurred investigation	at the tim	e, date and pinion, deat	d place, a	nd due to the	cause(s) and date and plac	manner as se, and due to	stated. the cause)(s)
	To the within 2.	Σ	29b. Signature and title of certifier	Manh.			c. License				29d. Date sig			
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	Sta Registr		31. Date filed (Monthly, 201 200	6 32 Registra	ar's Signature	marks	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Bertha Elizabeth Garrison 5:45 A. M 2006 June 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie 1570 Annapolis Drive Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 216 74 2850 Jan. 16, 1964 Director 42 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehoven jinjury or other traumatic event, Ita Medical Examiner must be notified at 1 ☐ Yes 2K No Maryland Anne Arundel Glen Burnie Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 1570 Annapolis Drive 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Operator Cleaning Service 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Bochniak William Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1570 Annapolis Drive Glen Burnie, Maryland 21060 William Garrison / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 6/15/2006 Bayview Crematory 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Gregory Gonce Funeral Home, P.A. 21. Signature of Fundinal Service Licensee 169 Riviera Drive Pasadena, Maryland 21122 Z3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** izure disease or condition resulting in death) /Medical Due to (or as a consequence of): pulmovary disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) signed by the a ld be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? this certificete has autopsy performed? 1 Yes 1 Yes 2 No 2 🗱 No the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a To the Funeral [29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and the of 042820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3708 maintain Rd Pasadeva md. 2/122 deBoria 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sporte Registrar 2006 DHMH 17 Rev 1/2001

DHMH 17 HeV 1/2001

			1 - For State Registrar	State of M	laryland		artmen rtificate				lental Hy	giene Reg. No.	2006		944
ı	Physic /Medi		Decedent's Name (First, Middle, La	Ella Eliz	zabeth	n Grov	'e				2. Date of De Month	Day	Year 2 00 6		e of Death
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п	Funeral			Sex 7. A 1 □ M 2 X F		ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bir	thplace (Sta	ate or Foreign
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Ĕ	T I Pa		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		'	adowride	-		1	c. 06/	21/2006		Elkridge	, Maryla	and
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	7		A asmin of 30. Name a diaddress of person who	littamilar completed cause of d		23a) (Tyna 5	Print)	P	795	51	C . , BAUT	TUNS	115	200	06_
	9		YASMIN ALI HP				CATO	ME	AUSI	212	PATE	cima	280 ~	20 - 3	Pech
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 2 1 6 Registrer 19462 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BARRY **Physician** HARRIS 1447 PM 2006 MVE /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner JUHNS HUPKINS BAYVIEW BAUTIMUNE If Under 1 Year If Under 24 Months Days Hours 5. Social Security Number 6. Sex 8. Date of Birth (Month, Pay, **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 213.44.8458 1**X**M 2□F Months Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits NIA MD Baltimore, Completed by Funeral Director 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21213 Junewa 12 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hamor Good Foreman Tth arade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Mathews Harris rudu 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Bural Royte Number, City or Town, State, Zip Code) 1829 Monttord Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6/28/06 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Baltimore MD 06-23-06 Cemetem Innit 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of acility Vaughn C. Greene Funeral Services 4105 York Read Baltimore MD 21212 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death ARRYTHMIA Immediate Cause (Final MINUTES disease or condition resulting in death) Due to (or as a consequence of) HYPOXIA Sequentially full conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner NEUMONIA Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIONYUPATHY, TRAUMATIC BRAIN INSURY 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2L No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed P.O. Division of Vital Records, : Atter this certification tuneral director. s efter death.

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heetth and Mental Hygiene. Internately or items 23a or 28a-f ehow ant: If Item 27 ie marked other than "neturel; or items 23a or 28a-f ehow

item 27 i

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

traumatic event, the Madical Examiner must be notified at

State

Medical

29b. Signature and title of certifier

29c. License number D0051965 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUAH LECHTZIN, MD 4940 HOPKING BAYNEW CIRCLE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

(Check only one)

JUN 2 1 2006



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 1:50PM M John Cecil Hornick, June 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 603 Piper Road Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 ☐ F 58 212-48-0233 WV Director April 13,1948 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "neturel", or items 23a or 28a-f show 1 ☐ Yes 2 🛱 No Director Reisterstown MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Piper Road 21136 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1968-69 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Depertment of Health and Mental Hygiene.
Important: if item 27 is marked other then "ne eny injury or other treumatic event. It a Medis Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Cecil Hornick, Sr. Margaret R. Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Piper Road, Reisterstown, MD 21136 Bonnie Sue Hornick Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 6/19/06 Finksburg, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Reisterstown, MD 21136 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) panireas cancer **Physician** 106 /Medical Due to (or as a consequence of): Examiner - disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) diabalas Exami that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vasi 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21200 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No nerel Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification Division To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After 1 Natural Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053070 06/14/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2/25/ OrKans St Is/ hunore 32. Redistrar's Signature 31. Date filed (Month, Day, Year) JUN 2 1 2006 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#7,perrH,0856,6/21/06 TT
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 0415 AM ARRISON ICTORIA TUNE 16 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner BAYVIEL MED CENTER JOHNS HOPKINS DACTIMORE | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days **Funeral** Hours 1□M 200F 215-90-7492 45 May 20, 1961 MD Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 2529 Yorkway Apt. B by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ?7 Is marked other than "nature traumatic svent, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Franklin D. Harrison Mary L. Wrightson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I othar tra Sean Harrison 3209 Lake Ave. Son Baltimore MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of t Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery June 19,2006 Parkville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. fan 3331 Brehms Ln. Baltimore Maryland 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CELL **Physician** LYMPHOMA, METASTASIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? signed Part It Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 🗆 Yes 2 ER/Outpatient ٩ 2 No 1. Inpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 DO 95 atoy Waterbury 30. Name and address of person who completed parse of death (Item 23a) (Type, Print) LARRY WATERBUR JABAC 4940 Easkern AUE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 1 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State o	ı Marylan	-	rtificate of		Wentarri	Reg. No. ?	06	19445
			1. Decedent's Neme (First	, Middle, La	ast)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physici		Orear Hall							May 19		real	2:30 am
Y	/Medic Examir		4e Facility Name (If not in	stitution, giv	ve street end nur	nber)			4b. City, Town, o	r Location of Dea	th 4c. Count	y of Death	
-		•	2002 Calvar	y Roa	ad				Bel Ai			Harfo	ord
	Funeral		5. Social Security Number		Sex 1XIM 2□ F	7. Age (In yrs.		If Under 1 Year Months Days			irth ay, Year)	9. Birthr	place (State or Foreign
	Director		219-28-4001		IXIM ZUF	73	Yrs.				, 1933	Mary	
	pu *		Usual Residence of Deced	lent County		10c. Cit	v. Town or Lo	cation					10d. Inside City Limits
	shor	ក		•	.1		Bel A						1 ☐ Yes 2√ No
	the N	ect	MD H	arfor	a		вет и	10f. Zip Code			10g. Citizen of	Whet Cour	
	with with De	ă	2002 Calvar	v Road	đ				21015		•	USA	
	eath	era	11. Marital Status	, 100	12. Was Dece	edent Ever in U,	S. 13. 1	Was Decedent of f Yes, specify Cub	Hispanic Origin? (Specify Yes or N	o- 14. Ra	ce - Americ	
21215-0020	n 72 hours after death with the Marylend "natural", or Items 23s or 28s-1 show edical Evantret must be notified at	by Funeral Director	1 □ Never Married 21 3 □ Widowed 4 □ Di	-	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? 2 XNo e		f Yes, specify Cub 1 ☐ Yes 2ሺ No		irto Rican, etc.)	Speci.	ack, White, fy: W h	etc. nite
9	2 hot	Completed by	15. De	cedent's E	ducation		16a. Deced	dent's Usual Occu	pation	n de in a	16b. Kind of E	susiness/In	dustry unk
215	hin 7.	be	(Specify only Elementary/Secondary (ade completed) College (1	-4or 5+)	life. I	kind of work done DO NOT use retire	during most of ward)	orking			
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pu	be filed with tal Hygiene. d other ther event, tre A	Be (17. Fether's Name (First, M							ame (First, Middle		me)	
yla	should be filed withir and Mental Hygiene. marked other than imatic event, tra Mi	흔	William	Masto	on Hall				Ruth	n Melissa	a Haga		
Maryland	2 sho and is me	.	19a. Informant's Name/Re	lationship ((Type, Print)			ng Address (Stree				, State, Zip	Code)
	1 and 2 Health em 27 I		Joyce Hall		se	1.00		Calvary	Road E				-
Baltimore,	Peges nent of ant: If it ury or c		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 4 ☒ Donation 5 ☐ O	nation 3 [emetery, crer	sition (Name of matory or other pla	ice)	Date	20c. Location	- City or 10	wn, State
Balt	permit. Departr Importe eny inji		21. Signature of Funeral S KOTIA	Mices ice	Wade / D	irector		late Anat 11timore,			. Baltin	ore S	Street
	Physician		23a. Rart1. Enter the dise shock, or heart failur	se, or com e. List only	pplications that cone cause on e	aused the death ach line.	n. Do not ent					-	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition		a	CHR	DNIL	REN	AL ff	HLURE	-		1-24pr -
	E AGIIIII.	_	resulting in death)			Due to (o	r as a conseq	uence of):					,
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	icete be executed physician and s the buriel-transit	Xal	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	i. e		Due to (o	ras a conseq	A .	A 0				
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68760,	tificete ng phy as the	Medical Examiner	resulting in death) Last	1		,	·	·	1100	OT PA			
Вох	h cer endir r use	an/			d		NYG.	STIVE	HEA		MEG	-	
	deal	SC	Part II. Other significent c	onditions o	contributing to de	ath but not resu	ılting in the u	nderlying cause gi	ven in Part I.	23b. Did	tobecco use co	ontribute to	the ceuse of deeth?
P.0	at the d by the	by Physician/	Livi	0=12	TENS	CARL	,			1 🗆	Yes 21 No	3 □ Prof	bably 4 Unknown
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Records,	The law requires that the death certificete be executed ate hes been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	Completed								24a. Was	s an autopsy ormed?	av	ere autopsy findings ailable prior to impletion of cause death?
Œ.	ysician: The law his certificate hes t I director, page 2 s	[등								1 1	es 2□No	10	∃Yes 2□ No
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5	Physical this carral dire	၉	1 Yes 2 No				ER/Outpatien	T 3LI DOA		Home 5 ☐ Res			y)
ñ	e age	Ö		Pending		of Injury h, Day Year)	28b. Time of Injury	Wo	ryat ⊮rk?]Yes 2 ∐No	280. Describe	how injury occu	160	
Sign	Attending or death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐	investigation Could not b	90 Diana	of Injuny - At ho	me farm str	eet, factory, office	7100 2 110	28f. Location	Street and Num	ber or Run	al Route Number,
Division	efter Direct	Certification:	4 ☐ Homicide	determined	buildir	ng, etc. (Specify	')	501, 140101), 511100			wn, State)		
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	o the	N E	29b. Signature and title of	certifier	0			29c. Licens			29d. Date signe		
	- 5 - 0		Auch	ina	400	D MC) .		141080	,	6086	06	
			30. Name and address of p	erson who	completed cause	e of death (Item	23a) (Type,	Print)	041080 CHUI LL	•			Md 21014
			ARCHANA	50	DO MO	12	208	CHUR	CHUI LU	F Rd	BELL	HR	Md 21014
	Sta	te	31. Date filed (Month, Day,	Year)	32, Re	egistrar's Signa	ture	وليتراث		* 11			
	Registr	ar	JUN	Z I ZU	AA OU	See See See	and the same						

			For State Registrar	State of M	arylan		artment of H				giene Reg. No.	2006	19446)
			1. Decedent's Name (First, Middle,	Last)	-					2. Date of De	ath Day	V	3. Time of Death	_
п	Physici /Medic		SYLVIA L. JOHNS							JUNE	17	, 2001	2:15PM	
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	r Location	of Death		4c.	County of Oeat	h	
			Maryland Gene		al		Baltir	nore	City					_
В	Funeral Director		5. Social Seburity Number 215–30–6888	3. Sex	ge (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birl (Month, Da 01/01	h y, Year) /193 4	Co	hplace (State or Foreign nuntry) MD	
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits	_
	death with the Maryland me 23a or 28a-f ehow r must be notified at	ō	MD										1⊠Yes 2□No	
	28a-	Director	10e. Street and Number		DAI	LTIMORI	10f. Zip Code				10a. Citiz	zen of What Co	ountry?	-
	3a or		2228 WALBROOK A	V/E			21216				USA		•	
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H	ispanic Or	igin? (Spec	cify Yes or No		14. Race - Ame		-
336	within 72 hours after death with the Marylanene. ene. Than 'naturel', or Iteme 23a or 28a-f show the Modical Examinar must be notified at	by Fui	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 Tes 2 If Yes, Give Year or Dates:			f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify.		tican, etc.)		Black, White Specify: BI		
215-0036	72 ho	Completed	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation	nt of workin		16b. Kir	nd of Business/	Industry	
2	e filed within 72 ho al Hygiene. I other than "natur vent, the Medical	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of work done of DO NOT use retired	during mos f)	SI OI WOIKIN	9				
7	filed wi Hygien other th	S	12TH			RETII	RED DIETA					of EDU	JCATION	_
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ă M	12 sh ih and 7 ie m traum	1	19a. Informant's Name/Relationshi			1	g Address (Street						Zip Code)	
Baltimore, Maryland 2	s 1 and 2 shoul f Health and Me Item 27 ie marl other traumati		IRVIN JOHNS/SON 20a. Method of Disposition		20b. P	lace of Dispo	FUNBRIDGE sition (Name of	- 1		LTMORE,		21212 cation - City or	Town, State	-
<u></u>	00		1 XBurial 2 Cremation		, a	emetery, cren	natory or other plac	. 1	06/00	100				
	permit. Pag Depertment Important: I any Injury o once.		4 □Donation 5 □ Other (Special Service)		1		ON FOREST		06/23		OWI	NGS MII	LS, MD	-
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			23a. Part1. Enter the disease of c shock, or heart failure. List o	omplications that caus	d the death							ريد ريد	Approximate	-
	Physician		Immediate Cause (Final			-1							Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as) MOI									_
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-	- 2V -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):			ــــــــــــــــــــــــــــــــــــــ					_
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Ö	e exe	Ä	resulting in death) Last	Due to (or as	a consequ	uence of):								
8760	The law requires that the death certificate be executed the best been signed by the ettending physician and aggle 2 should be detached for use as the burial-transit	dlcal		d	-					-				_
× e	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of progna	2004								-
Вох	eath certific ettending pl for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)				2	3d. Date of deli Month	ivery Day Year	
o	res that the de signed by the e I be detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it time of de	eatin 5	Other (specify)							
œ.	that i		Part II. Other significant condition	s contributing to death t	oul not resu	ulting in the u	nderlying cause give	en in Part	l.	23e. Did to	obacco us	se contribute to	the cause of death?	
Division of Vital Records,	uires sign id be	d by								101	∕es 2[No 3□Pr	obabiy 4 Donknown	
Ö	w require	Completed								24a. Was	an	24b. Were au	itopsy findings available	-
Re	he la e hes age 2	ᇤ								autop	sy med?	prior to death?	completion of cause of	
ta		0	25. Was case referred to medical					26 Place	e of Death	1 ☐ Yes (Check only o	2 2 No	1 ☐ Yes	2 No	_
5	Attending Physicien: r death. ector: After this certifice by the funeral director, i	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 DOA Oth	00		•		☐Other (Spec	cify)	
ਰ	g Ph er th		27. Manner of Death	28a. Date of Inju		28b. Time of				8d. Describe h			,	-
0	ttendin death. ctor: Aft / the fun	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ay rear/	injury		Yes 2□]No					
N N	= 00 -	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		jury - At ho	ome, farm, str	eet, factory, office		2	8f. Location (S City or Tox			ıral Route Number,	-
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	To the Hoepital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examinat	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	Nithin Fo the	Me	29b. Signature and title of certifier		. ~		29c. Licens	e number				e signed (Mont)		
	->-0		100	and h	ar))	99	53	5		10	-17-0	6	
	1		30. Name and address of person w	tho completed cause of	death_(Item	n 23a) (Type.				1	S	•	_	
	σ		KOF OWN	SU M.D	C/n	Mar	ryland	Gor	pral	Haso	Hal			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	J		المما م					
	Regist	ar	JUN 2 1	2006	E . A	H. So	outs o							
DH	MH 17 Rev 1/2	001		0		1								

ORIGINAL

OMAR KENNETH JACKSON 06-04198

Please Type or Print in Black Indelible Ink

NK UNK		State of Maryland / Department of H		lygiene	2006 101.1
Physicia		Registrar 1. Decedent's Name (First, Midgle Last)		Reg 2. Date of Death	3. Time of Death
ledical Examir		Umar Kenneth Jacks	ON	June 17, 20	
			City, Town, or Location of Deat pper Marlboro	.n	4c. County of Death Prince George's
Funeral			Under 1 Year If Under 24Hr	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-96-8119 12M 2 F 25 Yrs.	Months Days Hours Mir	1-2-	81 Country) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
*	٦	MD Balti	more		1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	of. Zip Code	10g	. Citizen of What Country?
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r death w	Funeral		specify Cuban, Mexican, Puerti		14. Race - American Indian, Black, White, etc.
safter der rafft, or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	s 2 No specify:		specify: Black
2 hours "natu			Isual Occupation (Give kind of of working life. DO NOT use re		6b. Kind of Business/Industry
5-0036 led within 7: Hygiene. other than	ompleted	24h CONSH	uction ()01	RKer	C. McCory
15-0 filed w I Hygic of othe	ပ	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Ma	aiden Surname)
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tr If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	dress (Street and Number or	Rural Route Numb	er, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is	٦	Brenda Calter (Mother) 1063	Upnor Re	d.Bay	to:MD 2/2/2
S L S L		20a Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State crematory or other from State Cr		Date	20c. Location - City or Town, State
[# 를 들 ^교 로		4 Donation 5 Other Specify: 1111110 O	Metery 6	-23-06	Batimore, MD
Balt permit. Depart Import injury		2004 Dist 1 MOD944 38	MERCHON 1	Street	- Pacto Mi) 21224
Physician /Medical		/23a. Part JEnter the osease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	node of dying, such as cardiac	or respiratory arres	t, shock, or heart Approximate Interval Between Onset and
kaminer	ı	Immediate Cause (Final disease or condition resulting in death) a, Contact Gunshot Wound of Head Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of):			
₩ g ₩	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
tra and	edical	d. UNPENDED AMENDED			
	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	ਕ	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal d Pregnant at time of death 5 Other	death 3 Ectopic pregn (Specify)	nancy	Month Day Year
BOy e death the atte	Physici	1 Yes 2 No 9 Unknown 9 Unknown			
i, P.O. B ires that the d signed by the	by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		acco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown
ords, aw requires	Completed			24a. Was ar	24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seed in by the funeral director, page 2 should 1	du	·		autopsy perform 1 V Yes 2	ned? death?
Vital Recolysician: The law	Be Co	25. Was case referred to medical	26.Place of Death (Check		No 1 Yes 2 No
F Vita	일	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3			esidence 6 🗸 Other: Scene
on of or or or or or or or or or or or or or		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) 28b. Time of Injury 0954 hrs	y 28c. Injury at Work? 1 Yes 2 ✓ No	Subject shot	ow injury occurred himself
/iSior r Attend ter death irector: n by the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa			reet and Number or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Certification:	4 Homicide determined (Specify) In a car		or Town, Sta Rt. 301 at Ma	nte) Irlboro Crossing, Upper Marlboro, M
To the Hos within 24 h To the Fun completely		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred one) Wedical Examiner: On the basis of examination and/or investigation,			
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		highi, mis	O.C.M.E.		June 18, 2006
3		30. Name and address of person who completed cause of death (Item 23a)	- MD 0100:		
	ate		Baltimore, MD 21201		
Regist		JUN 2 1 2006 Regue & Frank			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a, Ptil per Dr. 5556.06/21/106dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jackson 6:15 PM Rose 2006 Tune /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Honkins Baltimore Hospital City n/a 8. Date of Birth (Month, Day, Ye Feb. 19, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{SθX} 1□M 2□F Months Days Hours 577-48-36**7**0 Director 1937 Wash. DC 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow f Health and Mental Hygiene. Item 27 is marked other than "nature!", or iteme 23a or 28a-1 ehov other traumatic event, the Medical Exantinar must be notified at 1 Yes 2 No Director MD Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1838 Dutch Village drive 20785 Completed by Funeral Peges 1 and 2 should be filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Black Specify: Black 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self- Employed Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hudson Newberry Helen Butler 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin J. Rubio - Daughter 12763 Gazebo Crt. Woodbridge, VA 22192 20a. Method of Disposition
1 ☐ Burial 213 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ ō permit. Pege Department of Important: If any Injury or 5 Other (Specify) 4 Donation Metro Crematory June 21, 06 Baltimore, MD 22 Name and Address of Facility
25 Maryland Inc.
259 Frederick Road Bal; timore; MD 21228 21. Signature of Juneral Service License Ther the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Septic Shock **Physician** 2 days /Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, neading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Circhotic Liver Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physicien I be detached for use as the buria Certification; To Be Completed by Physician/Medical Urinary Tract Infection 4 days IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☑ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 INO 1 Tes 3 ☐ Probably 4 ☐ Unknown certificete has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Peath
1 Natural
2 Accident 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Sus, I. The Johns Hopkins Hespital, 600 North Wolfe Street, Boltmore, Maryland

31. Date filed (Month, Day, Year)

JUN 2 1 2006

Research Maryland State Registrar Barles DHIVIT TO Fiev 1/2001

			1 - For State of Registrar		artment of Health rtificate of Death	h	giene 2006	19449
	Physici	an	1. Decedent's Name (First, Middle, Last)	-		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	Dorothy Lee Jackson			June	19 3006	
	Examin Funeral Director	4	4a. Facility Name (If not institution, give street and num Union Memorial Hospital 5. Social Security Number 215-40-2368 6. Sex 1 □ M 2 ☒ F	ber) 7. Age (In yrs. last birthday) 63 Yrs.	Baltimore If Under 1 Year If Under Months Days Hours	City or 24 Hrs. 8. Date of Birth	4c. County of Dea	thplace (State or Foreign
	ס		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	vantion.			
	laryla hov	ō			onkton			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	288-1	rect	MD Baltimore 10e. Street and Number	TAI	10f. Zip Code		log. Citizen of What Co	
	h with	al Di	930 Monkton Road		21111		United Sta	•
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f e-how amy njury or other traumatic event. The Medical Examinar must be multified at ODG.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Deced Armed For 1 □ Yes. 3 If Yes, Give Year or Da	No	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 Yes 2 XNo Specify	an, Puerto Rican, etc.)	Specify:	
<u>5</u>	"natu	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business	/Industry
12	within lene. than	Completed	Elementary/Secondary (0-12) College (1-	4or 5+)	Support Loca	tor	State Gove	ernment
	other	BeC	17. Father's Name (First, Middle, Last)			her's Name (First, Middle,	Maiden Sumame)	
<u>Jar</u>	Menta Menta arked artc ev	To E	Clarence Thomas Ryan		Mar	garet D. Dau	ghton	
Maryland	2 sho and l		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numb		, , , , , , , , , , , , , , , , , , , ,	Zip Code)
	1 and Health Bm 27 ther t		Gail D. Jackson, Daughte	er 930 M	onkton Road, I		21111 20c. Location - City or	Tour State
Baltimore,	ages ont of I t: If its		Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)		Cimonium, Mar	
뵱	artme ortan		21. Signature of Funeral Service Licensee	-	2. Name and Address of Facil		•	-
മ്	Depariment of the period of th		Stammer	M01113 Du	laney Valley, P.	A. 200 Padonia 1	Road, Timoniu	m, MD 21093
12	Physician /Medical		resulting in death)	rosclentic (er the mode of dying, such as	\wedge	est,	Approximate Interval Between Onset and Death
	Examiner		Due to (c	r as a consequence of):	Distage			Sueles
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a consequence of):	, , –			Jean
V	ocuted ind transl	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	betes Mellit	vs			10 years
9	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (o	r as a consequence of):				
68760,	physics the t	edicai	d					
P.O. Box (or Attending Physicien: The law requires that the death certifure death. Director: Atter this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use a	Physician/Me	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	ivery Day Year
	w requires that been signed t should be deta	ρχ	Part ff. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part		baceo use contribute to es 2 □ No 3 □ Pr	o the cause of death?
Division of Vital Records,	: The law recete has be page 2 sho	Completed				24a. Was a autops perfor 1 Yes	y prior to	utopsy findings available completion of cause of
≝	sicien certifi rector	Be	25. Was case referred to medical examiner?		Other	ce of Death (Check only on		
ō	Phys r this eral di	. To	1 Yes 2 No 10 Pending (Month	patient 2 ☐ ER/Outpatier Injury 28b. Time of	IL 3LIDOA 4LIN	lursing Home 5 Reside	ence 6 Other (Spe ow injury occurred	cify)
<u>o</u>	nding ath. r: Afte e fun	ation	1 TNatural 5 ☐ Pending (Month 2 ☐ Accident investigation	, Day Year) Injury	Work? M 1 □ Yes 2 □		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
i≥	r Attendier death rector: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of building	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	28f. Location (SI City or Town	reet and Number or Ru	ural Route Number,
Ξ	urs eft rat Di							
	To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the tage of the design of the day one) 1 Medical Examiner: On the base and manner	sis of examination and/or in	vestigation, in my opinion, de	eath occurred at the time, d	ate and place, and due	to the cause(s)
	To To	-	29b. Signature and title of certifier		29c. License number	4 6 5	9d. Date signed (Mont	_
	0		30. Name and address of person who completed cause	of death (flam 22a) (Tunn	Deina	146-F8		1006
	3		Ankit Chiniler, MD.	Union Mana	rial Hospital,	Raltmore, Mi	21218	
·K	Sta	_	31. Date filed (Month, Day, Year) 32. P	gıştrar's Signature			V	
1	Registr	ar	JUN 2 1 2006 A	and the A	rack 1			

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 8:15A M EUSA JURGIS TUNE 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2XF Director 363.32.5708 March 2, 1915 Latvia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County other than "natural", or Itams 23a or 28s-f show vant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 939 Oella Avenue U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) accounting cost accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be flie Department of Health and Mental Hy Important: if Item 27 is marked othing any liquy or other traumatic event page. Teodors Johansons 2 Elizbete Zeltins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 939 Oella Avenue Ellicott City, Maryland 21043 Ms. Ilse Munro Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 06/14/2006 Baltimore, MD Bavview Crematory
22. Name and Address of Facility Synatury of Funeral Service Licenses Slack Funeral Home, P.A. var1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Interval Between Onset and Death nediate Cause (Final 5 Days **Physician** DIVERTICULUM OF Count disease or condition resulting in death) PERFORAND /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 PNo 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 -10 within 24 hours effer death.

To the Funeral Director: Affer this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 all patient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 ■ Natural Certification: 5 ☐ Pending 1 | Yes 2 | No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral (FC Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Ittle of certifier 051840 2006 no ddress of person who completed cause of death (Item 23a) (Type, Print) # 200 10700 CHARTER MISH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Amend #5 Per FH G857 7/17/@erdificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Kirtz. 3.30 AM Kobert 20 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore City Memorial Baltimore Union Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 219-28-4767 8. Date of Birth (Month, Day, Year) May 21, 1938 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days Hours **™** M 2□ F 68 Vrs Maryland Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 2818 Rose Lawn Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 years Automotive Manager 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Anna Marie Schultz Stewart Kirtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2818 Rose Lawn Avenue, Baltimore, Maryland 21214 Daughter Anna Kirtz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 23, ₩ Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licenses onnelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. complications that caused the death on one enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. Us Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) congestive Heart Month Due to (or as a consequence of) Month ocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of) YONGWA that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellirus 1XYes 2 No 3 Probably 4 Unknown physema 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the heat of my knowledge death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical **Examiner** The law requires that the death certificate be executed physicien ar P.O. Box 68760, use as the Division of Vital Records, has or Attanding Physician: this After thi s efter death. Il Director: A id in by the fu death. To the Hospital o within 24 hours of To the Funeral Di pelli

Physician

/Medical

Directo

Funeral

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Certification:

Medical

29a Certifier

KISHORE

Examiner

Funeral

Director

ital Hygiene. d other then "naturel", or iteme 23a or 28a-f ahow avent, the Medical Examinat must be notified at

mit. Pages 1 and 2 should be file partment of Health and Mental Higgertant: If Itam 27 is marked oth y Injury or other traumatic aven

permit.
Departn
Imports
any nju

filed within 72 hours after

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) JUN 2 1 2006

29b. Signature and title of certifier

Union Memorial Hospital, Baltimore, MD 32 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMH

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

June 20, 2006

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State of Maryland / Department of Health and Mental Hygiene 2 () () § 1 - Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death June 19 2006 **Physician** 5:20 A Annette Μ. Krapp /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multi Medical Center Towson Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 27, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Director Maryland 215-03-6838 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural; or Iteme 23a or 28a-f show any Injury or other traumatic event, the Weddial Examiner must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 THE 2 No Directo N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1210 Battery Ave. 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 10 Secretary M.T.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) В. Joseph Krapp Antoinette Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Fox Chapel Drive Lutherville, Maryland 21093 Margaret Mary Arthur (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 6/23/06 Brooklyn Park Maryland 22. Name and Address of Facility. McCully-Polyniak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 21230 21. Signature of Fugeral Service Licensee 7 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician a detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 1 Tyes 2 No 4 | Unknown INFFLTIOUS COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 25 No this certificate 1 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) クタタテノチ 10 who completed cause of death (Item 23a) (Type, Print) 7700 TOWGON

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

82. Registrar's Signature

		,	1 - For State Registrar	State o	f Marylar				ealth a Death		lental Hyg	giene	006	19	453
46			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea			3. Time	of Death
	Physici: /Medic		Laverne M.	Knicker	bocker	, JR.					Month June	Day 15	Year 2006	4:45	A M
	Examin		4a. Facility Name (If not institution, give	e street and nur	nber)		4b. City	, Town, or	Location of	ol Death		4c. C	ounty of Deat	h	
	3		Elternhaus Ass	isted I	Living			ayto	n			Н	oward		
	Funeral		5. Social Security Number 6. S	Sex IDXM 2□F	7. Age (In yrs.	.,	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Da)	h v. Year)	9. Birt	hplace (State	or Foreign
ı,	Director		227-05-1240 Usual Residence of Decedent		9	7 Yrs.					Feb. 6,	1909	Nev	v York	
	land		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d, Inside	City Limits
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	r 288	Director	10e. Street and Number				10f. Z	ip Code				10g. Citize	on of What Co	untry?	
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	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	J.S. 13.	Was Dec	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14	Race - Ame Black, White		
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<u> </u>	shound M	-	19a. Informant's Name/Relationship (,		ng Addres	s (Street a			I Route Numbe	r, City or	Town, State, 2	(ip Code)	
Z	alth a		Robert Knickerbo	cker/Sc	n						el, MD	2070			
ē,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other treumatic ev 2006.		20a. Method of Disposition			Place of Dispo	sition (Na	ame of other place	g)	D	ate	20c. Loca	ation - City or	Town, State	
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_	2 2 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	288. Place	of Injury - At h	iome, larm, str	eet, facto	ry, office		2	281. Location (S. City or Town	treet and i	Vumber or Ru	ral Route Nu	m <i>ber</i> ,
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	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	niner: On the bi	asis of examina	owledge, deat ation and/or in	occurre vestigatio	d at the tim n, in my op	e, date and inion, deat	d place, a th occurre	and due to the c ad at the time, d	ause(s) ar	nd manner as lace, and due	stated. to the cause	(s)
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		4	For State Registrar	State of Ma	aryland		artment of				giene Reg. No.	006	1945	Annual Parkets
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examinat tated.	ion and/or in	vestigation, in r	my opinion, d	eath occurre	d at the time,	date and pla	ace, and due	to the cause(s)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10d per fh 9856 6-21-06 vt
State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 JUNE **Physician** 2006 11:35 P M KATZNELSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE LEVINDALE HEBREW HOME | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01/21/1949 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MD Yrs 217-48-1118 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 BALTIMORE N/A MDDirector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21209 2507 SHELLYDALE DRIVE Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. item 27 Is marked other than ' other treumatic event, If e Mar College (1-4or 5+) Elementary/Secondary (0-12) PSYCHOLOGY PSYCHOLOGIST 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HALPERN KATZNELSON IDA 7 MEYER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2507 SHELLYDALE DRIVE - BALTIMORE, MD 21209 EVA KATZNELSON / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Dep. rtment of H
Importent: If ite
eny injury or ot
on. 1. ROSEDALE, MD CHOFEYZ"CHAIM"CONG 06/20/2006 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE RENAL FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 X No PARKINSONS DISEASE 3 Probably 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RETENSION RINARY 24a. Was an autopsy performed? Yes 200 No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 No death. 2 Accident after death Director: in 24 hour.

the Funeral Direc.

In filled in by th 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D006332 them H. WINDTHING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 21215 2434 WIBELEVEDERE AVE MD GIZAW WOLDEHIWOT

State Registrar 32. Refistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh e856 6-21-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 340 A M MOLAN Kessler 18 June 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of manyland Medical Centers. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore, mo N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/12/1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₹M 2□F Months 213-32-3638 69 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 1 Yes 2 □ No MOBILE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 HIGHLAND WOODS DRIVE WEST 36608 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: RESERVES WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **PROPRIETOR** PAPER PRODUCTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **KESSLER** HERBERT SAMUEL **ESTHER** RICHMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
530 HIGHLAND WOODS WEST-MOBILE, AL 36608 19a. Informant's Name/Relationship (Type, Print) CAROL KESSLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ANSHE NEISAN 06/20/2006 ROSEDALE, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelogeneaus Leutemia Acute Lyed Due to (or as a consequence of): Sequentially in conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown nditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

and

Physician

/Medical

Examiner

10a State

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23a or 28a-f ehow

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filed within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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"natural",

other

permit. Pages 1 end 2 should be filed v Department of Heelth and Mental Hygie Important: if Item 27 is marked other It eny injury or other traumatic event, Ital once.

Director

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Completed

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for use as the burial-transit page To the Hospital or Attandin within 24 hours effer death.
To the Funersi Director: Aff completely filled in by the fur

or Attanding Physicien: The law requires that the death certificate be executed in the death certificate be executed.

Division of Vital Records, P.O. Box 68760,

Examiner

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Certification: To

Medical

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Registrar

IF F	EMAL	.E:			
23b	1 🗆		12 n	nonths	
Part	II. Ot	her si	gnific	c ant c	01

2 No 3 Probably 4 □Unknown 1 🗌 Yes

24a. Was an autopsy rmed? 2X No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

26. P	lace of Death (C	heck only one)	
ther: 4 [Nursing Home	5 ☐ Residence	6 ☐Other (Specify
ury at		Describe how inj	

1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury a Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

2×10

5 Pending

examiner?

1 ☐ Yes

27. Manner of Death 1 Natural

(Check only

and C. Ma mo

JUN 2 1 2006

MD 15875

29c. License number

29d. Date signed (Month, Day, Year) June 18, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corol Ma, 223. Greene St. Baltwore, MO 2120

Hospital:

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 5 per fh 8856 6-21-06 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day JUNE 16 2006 6:50A KOLLER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 115-24-2901 8. Date of Birth (Month, Day, Year) 10/30/1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1√ M 2□ F Days POLAND Yrs. 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes X ☐ No BALTIOMRE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 4730 ATRIUM COURT #260 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNKNOWN KOLLER LUBA DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4730 ATRIUM COURT #260 - OWINGS MILLS, MD 21117 SALLY KOLLER / WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHIZUK" AMUNU O'CONG. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/20/2006 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final OUD CATO disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

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10a. State

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id 2 should be filed within 72 hours after death with the Marylan lith and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28e-f ehow retemmentic event, the Medical Examinar must be notified at

1 1 and 2 st of Health ar 1 item 27 if or other tr

permit. Pages 1 Department of H Important: if ite any injury or ot once.

Baltimore, Maryland 21215-0036

Box 68760,

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within 24 hours a To the Funerei C completely filled

Completed by Physician/Medical Certification: To

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death | Check only one) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence Other (Special Speci Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 🗌 Suicide 4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) JUNE 16 2000

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

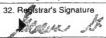
AALON CHARLES, MD Charles Baltemore no 21200 6601 N.

31. Date filed (Month, Day, Year) Registrar

Medical

29a. Certifier

JUN 2 1 2006



State of Maryland / Department of Health and Mental Hygiene Of Certificate of Death

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122 y		**	5. Social Security Number		arsing	7. Age (In y			If Under		I da.	24 Hrs.	8. Date of Bi		ntg		
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with	a or 2	Dir	106. Street and Number 107. Zip Code 109. Citizen of What Cot 22031 USA									t Count	try?				
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Records, P.O. Box		Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date								d. Date of Month		y Day Year				
J. 15	ned b		Part II. Other significant c	nditions	contributing to d	eath but not	resulting in t	he un	derlying ca	ause giv	en in Part	l.	23e. Did	obacco use	contribut	e to the	cause of death?
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Division of Vital Records,	s been sign	Completed											24a. Was		24b. Werr	autop	sy findings available
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4	1		30. Name and address of p	erson who	completed caus	se of death (I	tem 23a) (T	ype, F	Print)								
U			Kirti Voh	ra M	.D. 77	10 Br	adle	у :	B1vd	В	ethe	sda	, Md.2	0817			

State Registrar 31. Date filed (Month, Day, Year) JUN 2 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 6 19460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4:35PM Lambert Bernice 00 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ivanhoe Avenue Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours Min. 1 ☐ M 2 🔀 F 217.22. 0940 03.25. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimone MD 1 No 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21212 US4 tvenue 4417 Ivan hoe 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 12tharase 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Franklin Kenneth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Avenue Balt MD 21212 Konardo Wood vanhoe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 21/06 06 oudon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Vaughn C. Greene Funeral Services 4905 York Road Baltimore MD 21212 MO 13 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FALLURE THRIVE 70 Due to (or as a consequence of): Sequentially list conditions, if any, feating to infile diate Due to (or se a nonequence of) Rd. Date of delivery Month Day Year e contribute to the cause of death? 3 Probably 4 Inknown

29d. Date signed (Month, Day, Year)

16, 2006

JUNE

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Completed by Funeral Director

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-4 ehromany injury or other treumatic event, the Menters Experience.

Be Completed by Physician/Medical Examiner physicien and s the burial-transit မ After this c funeral din Certification: To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Aft 29a. Certifier

Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopic pregn		- 0	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not re		e given in Part I.		use contribute to the cause of death?
ATRIALF	7BRILLATI	0~.		24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 25 No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 🗆 Yes 2500	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA	Other: 4 Nursing I	dome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Malatural 5 Pending 2 Accident investigation		Injury	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	y occurred
3 Suicide 6 Could not b		nome, farm, street, factory, of	ice	28f. Location (Street ar City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurred at the ation and/or investigation, in a	ne time, date and place ny opinion, death occ	e, and due to the cause(s urred at the time, date and	and manner as stated. I place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SHAWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



ORIGINAL

29c. License number

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N. CALVERT

21218

MD

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** arcissie DSCOM 2006 0:30 Am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Frederick Villa Nursing Home Baltimore 8. Date of Birth (Month, Day, Y 01/13/1921 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 20 F Yrs. Virginia Director 9918 85 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nant of Health and Mentel hygiene. ant: if item 27 is marked other than "nature!, or items 23s or 28s-f show ury or other traumetic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXYes 2 ☐ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4504 Rokeby Rd. Funeral 21229 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify. \$ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 6 years Domestic Homes 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Eddie Crawley Okary Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4504 Rokeby Rd. Balto., Md 21229 Deborah A. Lipscomb / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: if any injury or 6/24/06 Turbleville, VA Crossroads Church Cemetery 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses Dnes 638 N. Gilmor St. Balto., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attanding physician and for use as the buriel-trer Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Decubitus ulcers 3 Probably 4 Unknown 1 Yes 2 No ours after death. •eral Director: After this certificate has been signe filled in by the funeral director, page 2 should be þ Malnutrition - moderate 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ▲ Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Manner of Deat 28d. Describe how injury occurred 1 Natural 28 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Cestifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier.

Dr. Rodolfo Fernandez 405 Frederick RD. Catonsville, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

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			1- For Amend Item 2	23a State of Ma	10836	,08 921 Cer	706thBi	Health an f Death	d Mental H	ygiene Reg. No		19462
	Dhusisi		Decedent's Name (First, Middle,	Last)					2. Date of D			3. Time of Death
	Physici /Medic		Mary Lee Lowery					_	June	11	ay avear	11:30PM
	Examir	ner	4a. Facility Name (If not institution,	give street and number)	11 .	11	4b. City, Town	, or Location of D	leath (-	40	o. County of Death	
			5. Social Security Number 6	Jeneral Sex 7. Ac	TOS	ast birthday)	If Under 17 e	ar If Under 24	Hrs & Date of B	4		l (0)
	Funeral Director		215-30-7674	1□M 2X F	70	Yrs.	Months Day		Min. 8. Date of B (Month, C	1935") Mary La	lace (State or Foreign itry) and
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	Ba-f	ecto			1	- CHINI				,		1 K∏ Yes 2 ☐ No
	with t	ក	10e. Street and Number 2019 N. Monroe Street	_			10f. Zip Code 212			_	itizen of What Cour JSA	itry?
	death with the Maryland me 23a or 28a-f ehow Frant by notified at	Funeral Director	11. Marital Sfatus	12. Was Decedent	Ever in U.S	S. 13. W			7 (Specify Yes or N		14. Race - Americ	an Indian
9	after dez	F	1 Married 2 Married		No				? (Specify Yes or Nuerto Rican, etc.)		Black, White,	etc.
78	ours ours	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	□Yes 2🖺 N	lo <i>Specify</i> :			Specify: Diaci	
\(\frac{1}{2}\)	within 72 hours ane. then "natural", he Medical Exe	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give k	ent's Usual Occurred of work dor	e during most of	working	16b. K	(ind of Business/Inc	lustry
25	withir ene. then	E C	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	i+)	Janito	O NOT use ret rial	red)		Act	tion Co.	
7 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	filed Hygid Sther	C	17. Father's Name (First, Middle, La	st)		- Carrie		18. Mother's	Name (First, Middle			
20 aryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "natural", raumatic event, the Medical Exe	To Be	Jack Lowery					Helena	_		•	
Mary	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hyglene. Item 27 te marked other then "natural", or Iteme 23a or 28a-f ehos other traumatic event, the Medical Examinations to rutified at	ľ	19a. Informant's Name/Relationship Bonita Lowery	(Type, Print) daughter		19b. Mailing 734 Cu	Address (Streenberland	et and Number of Street B	altimore, M	ber, City o arylai	or Town, State, Zip nd 21217	Code)
je j	f Healitem		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of atory or other p	(laca)	Date	20c. Le	ocation - City or To	wn, Sfate
Baltimore	permit. Pages 1 and 2: Department of Health an Important: If item 27 to eny Injury or other traugue.		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	Zion Cen		· · · · · · · · · · · · · · · · · · ·	e 17, 2006	Lan	isdowne, Mai	ryland
Salt	permit. Departr Imports eny Inju		21. Signature of Funeral Service Lic	censee		22.	Name and Add	fress of Facility	Wylie Funer	al Hor	me P.A.	
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused by one cause on each lin	the death.	Do not ente	the mode of d	ying, such as care	diac or respiratory	arrest,	~ ·	Approximate Interval Between
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9		9	IF FEMALE:	00 11								
) ds, P.O. Box	leath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 □ E	ctopic pregnar	су			23d. Date of deliver Month	ry Dav Year
o.	by the detached	ysic	1 ☐ Yes 2 M No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of dea	ath 5∐i	Other (specify)					. ou.
ص َ	thet deta	y Ph	Part II. Other significant conditions	confributing to death bu	of not resul	ting in the und	derlying cause of	given in Part I.	23e. Did	tobacco u	use confinbute to the	e cause of death?
w₽ sp	The law requires thet the death certifi ate hes been signed by the attending page 2 should be detached for use as	d by							10	Yes 2	□No 3□Proba	ably 4 Nnknown
43	law recessions been as been 2 short	Completed							24a. Was	an	24b. Were auton	sy findings available
tha	The lav	E								ormed?	prior to com death?	pletion of cause of
ita',		Be C	25. Was case referred to medical examiner?					26. Place of I	1 ☐ Yes Death (Check only	2 No	1 1 105	2U N0
>	Physicia this cerr al direct	2	1 ☐ Yes 25 No	Hospital: 1 Inpatier	nt 2 E	R/Outpatient	3□ DOA	thee			6 ☐ Other (Specify,)
Ę	ding Ph h. After th funeral	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Dafe of Injur (Month, Day	Year) 2	28b. Time of Injury	28c. In		28d. Describe	how injur	y occurred	
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	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical Certification;	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the stigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time.	cause(s) date and	and manner as sta place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	0 0.0			29c. Lice	nse number		29d. Dat	te signed (Month, D	ay, Year)
	(Ollas	Y. SPV.	00		80	1562		7	-11-0	2
_	(n)		30. Name and address of person wh	o completed cause		23a) (Type, P	rint)	~~~	1	7		11 . 1 1
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	Sta Registra	_	31. Date filed (Month, Day, Xear)	32. Registra	Signate	rade			-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 11:20 AM Leitz June 16, 2006 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Belair If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
November 2,1926 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 1 M 200F 79 Maryland Director 216-20-3259 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA iteme 23a 30 Patapsco Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No 1 Never Married 2 Married 1 and 2 should be filed within 72 hours afte Health and Mental Hygiene. em 27 ie marked other then "naturel", or i Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ethyl Fetrow Krouse Andrew Krouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a 1612 Lynch Road, Dundalk, Maryland 21222 Debbie Zoch Daughter June 20, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit Page Deparment o Important: if any in ury or once. Meadowridge Cemetery 2006 Halethorpe, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune lal Service Licenses 22 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** vicek disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ŏ in the past 12 months?
1 ☐ Yes 2 No Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has birector, page 2 s 2 1 Yes Division of Vital director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 ☐ Yes 3 No 2 ☐ EB/Outpatient 3□ DOA this After thi 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Injury 1 Natural 5 Pending 1 TYes 2 TNo death. investigation 2 Accident within 24 hours after death To the Funerei Director: , completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide fo the Hospitei 29a. Certifier 📉 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title officertifier 0 pleted cause of death (Item 23a) (Type, Print) address of person who

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year,

22. Registrar's Signature

06-03256 Seegars Lowery

Please Type or Print in Black Indelible Ink

eegars Lowery		State of Maryland / Department of Health and Mental - For State Certificate of Death		g. No. 200	6 1946
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 1136 hrs
Jeuicai Examini Z		Seegars Lowery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	May 14, 20	4c. County of Death	
_		Holy Cross Hospital Silver Spring		Montgomery	
Funeral Director	L	5. Social Security Number un 6. Sex 1 X M 2 F 55 Yrs. Isst birthday) 1 X M 2 F 55 Yrs. If Under 24 Hours Months Days Months Days Months	h(MM/DD/YYYY) 9. Birt Foreig , 1950	hplace (State or unk n untry)	
any	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits
* "	ا ج	MD Montgomery Silver Spring			1 Yes 2 X No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code 8712 Colesville Road #409 20906	10	og. Citizen of What Cour USA	try?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	σı	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1		White, etc.	can Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa	Be Compl	17. Father's Name (First, Middle, Last) unk 18. Mother's Na	ame (First, Middle, N	Maiden Surname)	unk
D 21 should and Med 7 is mai	٩	19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 19b. Mailing Address (Street and Number) 111 Penn Street Ba		· · ·	, Zip Code)
ore, MD es I and 2 sho of Health and If item 27 is her traumat	ŀ	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State
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Perm Perm Depu		21. Since of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Boa Baltimore, MD 21 23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			
Physician Medical aminer	1	23a. Pal I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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rted d ansit		events resulting in death) Last Due to (or as a consequence of): d.			
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Box he death of the attent hed for us	hysi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Didto	obacco use contribute to	the cause of death?
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Division spital or Attendi hours after death. meral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify)	28f. Location (S or Town, S	Street and Number or Ru State)	iral Route Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the caus red at the time, date	se(s) and manner as star and place, and due to the	ted. e cause(s)
To To	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Patriciaronica-Pollehous O.C.M.E.		May 15, 2006	
		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltin 	nore, MD 2120	1	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist	rar	111N 2. 1 2006 December 1858 1868 1868			

			·	State of Mar			Health and N	-	_	
		1	For State Registrar		•	ertificate of			ag. No.	6 19465
			1. Decedent's Name (First, Middle, Las	()				2. Date of Deat	h _	3. Time of Death
	Physicia /Medica		Harold		Mat	Hison		June	19 2000	0850 AM
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			5. Social Security Number 6. S	pkins Ho	Spital	JG av) If Under 1 Yea	I TI Under 24 Hrs.		1	U/A
	Funeral Director			M 2□F	711 Yrs. 1851 Diritho 11 S. Yrs	Months Day		8. Date of Birth (Month, Day,	Year)	Sirthplace (State or Foreign Country)
			Usual Residence of Decedent					12.24.	1162	
	how		10a. State 10b. County	1	10c. City, Town o					10d. Inside City Limits
	8a-f	Director	MIN MIA		bu 171	more				1. EXYes 2 □ No
	a or 2	2	1703 E. Lafaye	the Aven	110	10f. Zip Code	1212	1	Og. Citizen of What	Country?
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f ehow the Modical Exercities must be cotified at	Funeral	11. Marital Status	12 Was Decedent Ev		13. Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-		nerican Indian,
9	after o	Ē	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Il Yes, specify Cu		Rican, etc.)	Black, Wi	21 .
21215-0036	Jral',	d b	3 Widowed 4 Divorced	Year or Dates:			·		Specify:	Slack.
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7.	withir ene. then	m C	Elementary/Secondary (0-12)	College (1,4or 5+)			rev		Bethleh	em Steel
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Maryland			19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Stree	et and Number or Rui		~	
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the	ne death. Do not					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition			morrh	agic St	roke		Onset and Death
	/Medical Examiner		resulting in death)		consequence of):		3			several
	3	_	Sequentially list conditions,	b. Due to (or as a	consequence of):	5100				years
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× 68	The law requires thet the death certifical ele has been signed by the ettending phypage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE:	23c. If yes, outcome of	oregnancy					i i
torne lokpar Milial Records, P.O. Box	eath c	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetel death	3 ☐Ectopic pregnan			23d. Date of d Month	Day Year
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10K	s their		Part II. Other significant conditions of	,	_	e underlying cause o	given in Part I.			to the cause of death?
a) pi	w require been sig	fed	10bacco	abus	ك			1 🗆 Ye	s 2 No 3	Probably 4 Driknown
x+cme b	lawr nes be e 2 sh	Completed by						24a. Was a autops	v prior t	autopsy lindings available o completion of cause of
5 =	sician: The law s certificete hes b lirector, page 2 s							perform 1 Tes 2		? es 2□ No
→ 5	sician	Be	25. Was case referred to medical examiner?	Hospital:	a∏50/0		26. Place of Deat		*	
00	Physer this	n: To	27. Manner ol Death	28a. Date of Injury (Month, Day)	2 ER/Outpa	e of 28c. in	4 Nursing no		nce 6 Other (S)	oecity)
Z'io	ath. r: Afte	atlo	1 Natural 5 Pending 2 Accident investigation		Ye <i>ar)</i> Inju		ork? □Yes 2□No			
P# 4	r Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, larm (Specify)	, street, factory, offic	е	281 Location (St City or Town	reet and Number or n, State)	Rural Route Number,
۵	Hospital or Attending Physician: 14 hours after death. Funerel Director: After this certificately filled in by the funeral director.	. г								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	xamination and/o	leath occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
_	To the within 2 To the comple	Me	29h. Signature and title of certifier			29c. Lice	nse number	2	9d. Date signed (Mo	nth, Day, Year)
	->-0		Dristine &	. Berry,	M.D.	RE	5-000)	June 19	,2006
	6		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	\-\\-c =	GOON W	CLEESTRE	,2006 ET ERC MD21287
			CRISTINE E. B	EKKAI, M.D	· JOHN	D HOYKIN	12 LE124,111A	-	BALTIM	CRC MD21287
	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 1 2	116 Jaguar	3 Signature	Goardi				
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DHMH 17 Rev 1/2001

Registrar

JUNE

DOUGLAS MITCHELI

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#8 PER FH G856 6/21/06 WS
State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ecial Rave Mosley 2006 June 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Wesley Nursing HOME 7. Age (In yrs. last birthday). 6. Sex 8. Date of Birth (Month, Day, Year 1913)
9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-22-7759 Usual Residence of Decedent 1□M 2 F Director June 25, 2006 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Evandrier must be notified at Baltimore 1 Yes 2 No Directo MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2339 21214 U.5.A Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 ¥Widowed 4 ☐ Divorced and Mental Hygiene. Is marked other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK 12+h Catholic Diocese permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel ၉ larence Dates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21209 -10 H. Dates 7 carterdale Rd 500 <u>victor</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ⊠Burial 2 ☐ Cremation 3 □Removal from State 28/06 * 4 □ Donation 5 □ Other (Specify) Owings Mills, MD Forest 21. Signature of Funeral Service Lipensee Name and Arbiress of Cacility eene Funetal Services Randallstown, MD 21133 berty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORUBROVASCULAR Physician ACCIDENT WEEKS /Medical Due to (or as a consequence of): Examiner ADVANCED CORUBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and signal signal The law requires that the death certificate be executed HYPLARTENSIVE CARDIOV physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2XNo 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CALCIFIC 24a. Was an ATTON page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mil 2006 our. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. - 2211 W- ROGERS AVE - BALTIMORE ROBERT ROBY E-32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUN 2 1 2006 State

DHMH 17 Rev 1/2001

Registrar

6/16/2006

06-04145 Sylvia McCormick

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		Certific	ate of D	eath		Reg. No.	200	c 101.c
Physician Medical Examine	,	1. Decedent's Name (First, Midd	le,Last)				2. Date of De Month	Day	Year	3/Time of Death 10/10/1815 hrs
iviedicai Examine		Sylvia : 4a. Facility Name (if not institution	L. McCormick	1	[4b.	City, Town, or Location	June 15,		County of Death	1815 IIIS
		Mercy Hospital	THE STREET WHILE THE THE THE	,		Baltimore	or Beauti	70. 0	odiny of Death	
Funeral	7	5. Social Security Number	6. Sex 7. A	ge (In yrs, last bir	_		er 24Hrs. 8. Date of B	irth (MM/DE		nplace (State or
Director	ı	218-44-4055	1 M 2 X F	58	Yrs.	Months Days Hours	Min. 09/02/1	1947	Foreigr Cou	intry) MD
ò	-	Usual Residence of Decedent 10a. State 10b. County	.	Lio on T						
ow any				10c. City, Town						10d. Inside City Limits 1 XX Yes 2 No
Maryland 28a-f show 1 at once.	힑	MD N. 10e. Street and Number	Ą	Baltin		Of. Zip Code		10a Citiza	n of What Coun	
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r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	501 E. Preston St	12 Was Deceden	t Ever in U.S.		21202 ecedent of Hispanic Orig			ISA I. Race - Americ	an Indian, Black,
death or iten		1 Never Married 2 M	arried Armed Forces	XX No		specify Cuban, Mexican	, Puerto Rican, etc.)		White, etc.	
after	濟.		orced If Yes, Give Year or Dates:			s 2 X No specify:			pecify: Black	
bours after "natural", Examiner	ᆰ	15. Decedent's Education (Spe Elementary/Secondary (0-12)				Jsual Occupation (Give of working life. DO NOT		16b. Kin	d of Business/Ir	dustry
36 thin 72 than edical	Completed		oonego (· · o.		Cools				m •	,
5-0036 ed within tygiene other tha	5	9 years 17. Father's Name (First, Middle	Last)	I	Cook	18.Mother	's Name (First, Middle,	Maiden Su	<u>rname)</u>	11
21215-0036 hould be filed within 7 d Mental Hygiens is marked other than 11 tic event, the Medica	8	Louis Matthew Sc	riber				Ruth Jones			
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ore, MC ss 1 and 2 sl of Health ar If item 27	- 1-	20a Method of Disposition		20b. Place		(Name of cemetery,	Date		cation - City or T	own, State
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Baltimo permit Pag Department Important: injury or of	+	4 Donation 5 Other S 21. Signature of Funeral Service		THE BUCCA		e and Address of Facility				,
Balt permit Depart Import injury	1	Semerla	Jones		638	N. Gilmor St.	Wylie Fune			
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760, ficate be g physic the bur	Me.	IF FEMALE: 3b. Was decedent pregnant in t	23c. If yes, outco	me of pregnancy					Date of delivery	
c 68 certif ending use as	l all	past 12 months?	I Live birtii	A ASSESSMENT OF THE PARTY.	Fetal o	death 3 Ectopia (Specify)	c pregnancy	M	onth Da	ay Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 V Un	known 9 Unknown		o otrici	(Openiny)				
Division of Vital Records, P.O. Box 68 tab or Attending Physician: The law requires that the death certificate and freeform. After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	5	Part II. Other significant condi	tions contributing to dea	th but not resultin	ng in the unde	erlying cause given in Pa				ne cause of death?
S, F quires en sign										ppsy findings available
cords law requii has been	Completed						24a, Was			mpletion of cause of
tal Rection: The certificate ector, page	5						1 Yes	2 🗸 No	1 Yes	2 No
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of Vil		1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ury 28b.	Time of Injury					
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Visi or Att fifer de Direct in by	<u> </u>	. 79	stigation 28e. Place of I	njury - At home, fa	arm, street, fa	actory, office building, et	c. 28f. Location	(Street and	Number or Rura	al Route Number, City
Di spital sours a neral l	Certification:	4 Homicide	rmined (Specify)	other-sce	ene		Baltimor	e, MD	r r r r r r r r r r r r r r r r r r r	ton St. 728
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To t Com	Medicar	29b. Signature and title of certific	and manner stated			29c. License number			te signed (Mont	1
	-	70/-1	12 1	43	1	O.C.M.E.		1.	16, 2006	
	-	30. Name and address of persor	who completed cause of	death (Item 23a)						
Ø			Assistant Medical E	xaminer 1		Street, Baltimore, N	MD 21201			
Sta Registra	te	31. Date filed (Month, Day, Year)	06 32. Registra	ar's Signature	MALL S					
Registra	al l	2011.11	A	₫F						

		1 - State Registrar		Otate of h	Maryland /	-	rtificate of			Reg. No	ZIIIIh	1946
Physicia /Medic Examin	cal	4a. Facility Name (resa Mora If not institution, g	ales ive street and numbe				or Location of Dea	2. Date of D Month June	7 Da	Year 2006 County of Death	
Funeral Director		5. Social Security N 213-12-0 Usual Residence of	Number 6.	Care - 5 Sex 7.7 1□ M 2□ F	Age (In yrs. last b		If Under 1 Year Months Days	aston If Under 24 Hr Hours Mir		ay, Year,	9. Birth	place (State or Foreintry) sylvania
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Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	11. Marital Status	chmans L	12. Was Deceder Armed Force	s?	13. \	10f. Zip Code 2 Was Decedent of If Yes, specify Cub	1601 Hispanic Origin? (aan, Mexican, Pue	Specify Yes or N rto Rican, etc.)	υ	JSA 14. Race - Ameri Black, White,	can Indian,
"natural", or	<u>م</u>	3 Widowed		If Yes, Give Year or Dates Education rade completed)	168	a. Deced	1 ☐ Yes 2 💢 No dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. K	Specify: whi	
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DHMH 17 Rev 1/2001

Mary Morales

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Katherine M. McQuade June 8, 2006 1:15 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8800 Old Harford Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🛱 F Months 100 Yrs. 213-05-2989 Dec 29, Director 1905 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21234 USA or Itams 23a 8800 Old Harford Road un k12. Was Decedent Ever in U.S. Armed Forces? ried 1 ☐ Yes 2 k No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Joseph McQuade Henrietta Morrison Lyges 1 and 2 s. Lyges 1 and 2 s. Lygerment of Health and Important: If item 27 is meany injury or other once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minetta Lightiser/neice 8400 Charles Valley Ct #C Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade ²² State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 un 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endstage
Due to (or as a consequence of): **Physician** -dementra ars /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter this entire Due to (or as a consequence of): Examiner Cause (Disease or injury the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Year Month 4☐Pregnant at time of death Day 5 Other (specify) 9□ Unknown 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed · ension 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funaral Diractor:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kendall R. Faulkner MD, 6565 N. Charles St JUN 2 32. Registrar's Signature 31. Date filed (Month, State Registrar

Morningside/

atherine Mic Duade

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Division tal or Attendir is after death all Director: A led in by the fu	fica	2 Accident 3 Suicide		origation, _				, farm, stree	, factory, o	office bui	lding, etc.	. 2				er or Rura	al Route Num	ber, City
Division of Vital Records, P.O. Box 68760, Collopial or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transition in by the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director.	Certification:	4 Homicide			(Specify)	Barn						14		n, State ensp		/ Road,	Stevenso	n, MD
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1	ŀ	30 Name and add	ress of persor	who compl	eted caus	se of death	ltem 23a	a)										
V		Carol Allan	, MD As	sistant M	ledical	Examin	er 11	1 Penn S	treet, B	altimor	e, MD	21201						
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	Physic /Medi		1. Decedent's Name (First, Midd	lle, Last)	MCFAR	LLAND	· · · · · · · · · · · · · · · · · · ·	2. Date of De Month	Day	Year	3. Time of Death
7	Exami		4a. Facility Name (If not institution Gilchrist Cent	on, give street and num cer for Hos	spice Care		own, or Location of		4c. Count	y of Death	1. •
	Funeral Director		5. Social Security Number 415-36-4430	6. Sex 1 ☐ M 25€ F	7. Age <i>(In yrs. last bin</i> 84	thday) If Under 1 Months	Year If Under 2 Days Hours		9/1921	9. Birthp Coun	place (State or Foreign htry) CA
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. Count MD Ba	, Ltimore	10c. City, Towr		-				0d. Inside City Limits 1 ☐ Yes 2 XNo
	th with th 23e or 26	al Dire	10e. Street and Number 1317 Stonet	oridge Ct	•	10f. Zip C	ode 286		10g. Citizen of USA	What Coun	try?
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	P \$ P 8		29b. Signature and title of certifier	2 No	uller		2564	3	29d. Date signed	,	
_	+		30. Name and address of person **Evaluation Very Company 31. Date filed (Month, Day, Year)	who completed cause	of death (Item 23a) (TD/660)	ype, Print) . Chau	les Stra	3 (t/Balt	ano	712	04
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*.			Continuum Care 5. Social Security Number 6. Sex	7 400 //0	um la at histholau	Sy If Under		ille If Under	24 Hrs	O Data of Birth		arroll	
	Funeral Director		5. Social Security Number 5. Sex 5. Social Security Number 6. Sex 1 Usual Residence of Decedent	X-	yrs. last birthday) 101 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, NOV • 30	Year) 1904	9. Birthpi Count Mary	ace (State or Foreign try) / Land
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215	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f show the Madical Examiner must be molified at	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of wo DO NOT u	rk done d	during most	t of work	ing			,
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Maryland	is should be and and and is mireum		19a. Informant's Name/Relationship (Typ							al Route Number,			
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nc	Jing I	ion	27. Many of Death	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	M	8c. Injury Work	at ?? Yes 2 □ I		28d. D <i>e</i> scribe hov	v injury occur	rea	
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28ø. Place of Injury - building, øtc. (S	At home, farm, stroecify)			. 40		28f. Location (Stre City or Town,	et and Numi State)	oer or Rural	Route Number,
	the Hospitel of the Salution of the Funerel Diplotely filled in holestely filled in	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred vestigation	at the tim	e, date and pinion, dea	d place, th occurr	and due to the cau ed at the time, dat	use(s) and ma e and place,	anner as sta and due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	I A A A A A A A A A A A A A A A A A A A	m.	290	. License	number	1	29	d. Date signe	d (Month, D	ay, Year)
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	30		30. Name and address of person who co	خق بندها	(Item 23a) (Type,	Print)	uf	Rec	ud	J. M. C.	50 Me	Sya	rylad
18	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 1 200	32. Registrar's S	Signature	esto 1							

			For State Registrar	State of Mar	•	•	ent of He ate of D		d Me		gienę Reg. No.	2006	19474
			1. Decedent's Name (First, Middle, La	st)					2.	Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Wilda	M. Melli	n					June		2006	12:00PM
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. Ci	ty, Town, or	Location of D	Death		4c. (County of Deat	n
			719 Maiden Choice	Lane, HR33	30		Catons					Baltin	ore
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last birthda	Month		If Under 24 Hours	Hrs. 8. Min.	Date of Birt (Month, Da	h y, Year)	9. Birth Co	nplace (State or Foreign untry)
	Director		212-22-3659	M 243F	81 Yrs.				A	UG 3,	1924	+ Wes	t Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location		-					10d. tnside City Limits
	sho sho	ō		1	,			:11_					1 ☐ Yes 2 No
	28a-f	Director	MD Balt 10e. Street and Number	imore			Zip Code	ville	<u> </u>		10a Citiz	en of What Co	uote/2
	with a or	ā	719 Maiden Choic	e Lane HR3	30	101.	21228				rog. o.u.	USA	array.
	na 23	Funeral	11. Marital Status	12. Was Decedent Ev		3. Was De		spanic Origin	? (Specif	v Yes or No	. 1	4. Race - Ame	ncan Indian.
_	ther d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Z No			37	spanic Origin n, Mexican, P	uerto Ric	an, etc.)		Black, White	
2	urs a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	į	1 ☐ Yes	2 🕅 No	Specify:				Specify: W	hite
	within 72 hours after death with the Maryland ene. Itan "natural", or itama 23a or 28a-f show he Madical Examiner must be mulified at	Completed	15. Decedent's Ed (Specify only highest gra				suat Occupa	tion uring most of	f working		16b. Kin	d of Business/l	ndustry
<u> </u>	thin 7	ple	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life	a. DO NO1	use retired)	anny most of	Working				
V	ed wi	S	12			Assoc					_	artment	Store
yland	be tile tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (F	First, Middle,	Maiden :	Sumame)	
2	Men Men arke	၉	Austin H. Reed						arl_				
MA	s 1 and 2 should be filed within 72 hours after death with the Marylan at Health and Mental Hygiene. It has the marked other than "natural, or itama 23a or 28a-f show then traumatic avent, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (Town, State, Z	
ສົ ໜົ	l and lealth im 27		H. Mary McKeown/	<u>Personal</u> Re	20b. Place of Dis			iue Noi	rth,		eter	Sburg,	FL 33710
5	M its		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Meadowr Memoria	rematory of	r other place)					
annor	Pa tant:		4 Donation 5 Other (Specif		Memoria	Par	k	6/	/24/0			lkridge	
n n	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other ance.		21. Signature of Funeral Service Licer	•								1 Home,	
_	40 = 4 d	_	Edward M. Gre 23a. Part1. Enter the disease, or com	gorchik								e, MD 2	Approximate
	Physician //Medical Examiner prize percented the prize transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	ry A	rter	y Ŧ	nfo	ret			Onset and Death
0	physi the t	dical	•	_d									
Ď.	w requires that the death certificate toes been signed by the attending physishould be detached for use as the table.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 W No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetat death	3 □Ectopic 5 □ Other	pregnancy (specify)				2	3d. Date of deli Month	very Day Year
Ţ	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlyin	g cause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
cords,	quire on sig uld b	Pd L	Hyperlipide	mia						1 🗆 Y	′es 2 🗆	No 3□Pro	bably 4 Unknown
္ဌ	law re as bee 2 sho	Completed	•							24a. Was		24b. Were au	topsy findings available ompletion of cause of
Ĕ	The is	E							_	autop perfor 1 ☐ Yes	rmed?	death?	
	sician: The la certificate has rector, page 2	a u	25. Was case reterred to medical					26. Ptace of	Death (C			1 1 163	20 140
	Physician: rthis certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3	DOA Othe					Other (Spec	ufv)
			27. Manner of Death	28a. Date of trijury (Month, Day)	(ear) 28b. Time	e of	28c. Injury Work			d. Describe h			//
0	Attanding F r death. ector: After by the funer	atlo	1 Patural 5 Pending 2 Accident investigation		ear) Irijur	M		es 2 □No					
DIVISION	P # 15 €	Certification:	3 Suicide 6 Could not b 4 Homicide determined		/ - At home, farm, (Specily)	street, faci	ory, office		281	Location (5 City or Tox	Street and m. State)	Number or Ru	ral Route Number,
	na Hospital 24 hours a na Funaral I	Medical (29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of niner: On the basis of each manner state	xamination and/or	eath occurr investigati	ed at the time on, in my opi	e, date and p inion, death o	olace, and	due to the dat the time, o	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the H within 24 To the F complete	Me	29b. Signature and title of certifier			1	29c. License	number			29d. Date	signed (Month	, Day, Year)
	/		Sono B.	wels	2111		D44	377			Jur	ne 13,	2006
, -	4		30. Name and address of person who										
2			Deneen Bowling	mo 711	Maider	ch	pice	Lune	. Cu	tons	vill	e, me	121228
	Sta Regist		31. Date tiled (Month, Pay Year) 20	06 32 Registrar	M cuicle v s Signatura	200	-					,	

	•	1 - For State Registrar	State of Maryl	land / Depa	artment of H	lealth and I	Mental Hyg	giene leg. No. 20	06 19475
		1. Decedent's Name (First, Middle, Las	st)				2, Date of Dea Month		3. Time of Death
Physici		Vera Mildı	red Norwood				June		06 2:30 A M
/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. County of	
LAGITIII	101	Continuum Care			Sykes	sville		Carr	011
Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
Director		217-46-7409	□M 2X1F	97 Yrs.	Months Days	Hours Min.	Apr. 27	1909	Maryland
		Usual Residence of Decedent							
ylan.		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
Mar F 8	to	MD Montgor	mery I	Burtonsv	ille				1 ☐ Yes 2XXXVo
1.28 r	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
3a o	Funeral Director	3112 Spencervill	e Road		20	866		US.	Δ
deati ms 2	erg	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		pecify Yes or No-		American Indian,
file file	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2/XNo				o Rican, etc.)		White, etc.
ursa Bil', o	þ	XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XXX No	Specify:		Specify:	White
be filed within 72 hours after death with the Maryland lat Hyglene. I dother than "natural", or items 23a or 28a-f show event, it is Madical Expiribly from that be notified at	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of Busin	ness/Industry
nin 7	ple	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retire	d)	Ag		
d with	no.	9th	ø	Ho	memaker			Own H	ome
at Hyge	BeC	17. Father's Name (First, Middle, Last,				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
ic enta	To B	Grover C. Hok	bs			Myrt	le Olive	Welsh	
ial y allo 2 is 2 should be filed with and Mental Hygiene, is marked other than aumatic event, its	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, St.	ate, Zip Code)
and 2 ealth a m 27 is		Jon Norwood/Son		3509	E. Ather	ton Lane	Ranebe	rrv TN	37890
ite; INITELY INITELY AT A TOO OO OO OO OO OO OO OO OO OO OO OO OO		20a. Method of Disposition	20	Ob. Place of Dispo			Date	20c. Location - Ci	
Datumore, permit. Pages 1 an Department of Heal important: if item 2 any injury or other		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		•	coln Cem.		7/2006	Dwonter	ad MD
it. P. ritan		21. Signature of Funeral Service Lines		OIL LIN	2 Name and Addre	ss of Facility D	7/2006 onaldson	Brentwoo	Home, P.A.
Dalt. Dermit. Departr Imports any inje		21. Signature of Fullerar Service Later	/	00160		ott Aven			20707
		Jane V	- TURELLE	1					Approximate
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. Due to (or as a column of the	Anhan		umon			Interval Between Onset and Death
\n =	ner	Sequentially list conditions, it any, leading to instructions cause. Enter Underlying	Due to (or as a cor	ns_quence of):					
ite be executed ysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U.	menti	5				
6 be exe sician a burial-		resulting in death) cast	Due to (or as a cor	nsequence of):					
te be	cal		d	N					
tifica ng ph as ti	Jed	IE EENALE.							
w requires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify)	у		23d. Date of Month	
that	Į d	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause gı	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
w requires to be signer should be	d by						1 🗆 Y	es 2□No 3	Probably 4 Quakhown
y red beer shou	Completed						24a. Was a	n 24h We	ere autopsy findings available
e lay	dm		4 - 11 - 11 - 11 - 11 - 11 - 11 - 11 -				autop	sy prio	or to completion of cause of ath?
	ပိ						1 🗆 Yes		Yes 2□No
VICIAN The sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ith (Check only or		
OI VITA Physician: this certific ral director,	မ	1 Yes 2 No	1 Inpatient	2 ER/Outpatie	nt 3 DOA	4 Darutsing F		ence 6 Other	
ng P	on:	27. Manner of Beath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wo		28g. Describe n	ow injury occurred	J
Attending r death. actor: After by the fune	cati	2 Accident investigation				Yes 2 □No			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Hospi 24 hours Funer etely fill	edicai		nysicien: To the best of my miner: On the basis of exa and manner stated.						
o the	₩ W	29b. Signalune and title of certifier			29c. Licens	se number		29d. Date signed (Month, Day, Year)
- × - 0		1 1 X X X X X X X X X X X X X X X X X X	11000	MI)	1) - (00542	218	06-12	-06
1		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)				
12		DR - Raman	B. Kanen	0/1	7 Malcal	m du	e wes	1 f minste	-06 MD 21157
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's S		anti I				,

			1 - For State Registrar	State of Maryla	nd / Dep			lental Hyg	_	
	Dhusia		1. Decedent's Name (First, Middle, I	_ast)				Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medi		Thach Nguy	en				June	18 200	
	Examir	ner	4a. Fecility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of De	eath
			Holy Cross Hosp				r Spring		Montgo	
	Funeral	1		. Sex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		220-39-4244 Usual Residence of Decedent		J 115.			Sept. 1	0 1935 N	. Vietnam
	land w		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	MD Prince	George's	Laur	-01				Y¥Yes 2 □ No
	death with the Maryland me 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number	deorge B	Daul	10f. Zip Code		1	0g. Citizen of What	Country?
	3a o		7607 Laurel Rid	ge Court		20707			USA	
	death me 2	Jera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.		Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - A	merican Indian,
9	or ite	F	1 ☐ Never Married 🏖 Married	Armed Forces?	į			Hican, etc.)	Black, W	hite, etc.
93	rel', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes Ž OX No	Specify:		Specify:	Asian
21215-0036	be filed within 72 hours after tal Hygiene. d other then "naturel", or ite	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup	during most of working	na	16b. Kind of Busine	ss/Industry
21	ithin	npidu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	-3		
2	ed w ygier yer th	S	12th	4	Prin	ter				hics, Inc.
P	d oth	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
$\frac{2}{8}$	should nd Men marke umatic	2	Ngoc Vi Nguy						uyen	
Maryland	0 0 = 0		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number	, City or Town, State	e, Zip Code)
	end ealth m 27		Hieu Tran/Wife		760	7 Laurel	Ridge Cou			20707
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3		cemetery, crei	osition (Name of matory or other pla	сө)	ate	20c. Location - City	or Town, State
Ē	Pag men lant: lury		4 □Donation 5 □ Other (Spec	cify) I		l Cemeter		/2006	Laurel,	
Sall	permit. Departr Imports eny Inju	1	21. Signature of Funeral Service Lic	. 10						Home, P.A.
	⊈ ∪ E ≝ q		anuel	ALXXX MO11			t Avenue,			υ7
_			23a. Part 1. Er ter the disease, or co shock, ir h + rt failure. List on	mplication that caused the dealy one sees on each line.	ith. Do not ent	ter the mode of dyir	ng, such as cardiac o	r respiratory arri	est,	Approximate Interval Between
	Physician		Immediate Ca e (Final disease or condition	Gastic	Carci	noma				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse						
	Examiner		Sequentially list conditions.	b						
(4)	ם פ	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	cuence of					
K	e law requires that the death certificate be executed has been signed by the attending physicien and pe 2 should be detached for use es the burial-transit	Eam.	that initiated events resulting in death) Last	c						
760,	e ex		rosuming in dodain, cast	Due to (or as a consec	quence of):					
876		lical		d						
89	ing p	Physician/Med	IF FEMALE:	and the second sections						
Вох	ath co	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy	,		23d. Date of o	delivery Day Year
	e de the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of of of the second of	death 5	Other (specify)			William	Day 76ai
P.O.	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use es th	P.	Part II. Other significant conditions	t contributing to death but not re-	culting in the u	ndorhina sausa au	on in Dart I	220 Did to	landa una anatributa	to the cause of death?
3,	signe signe	þ	Tak ii, oxior significant conditions	Continuing to death but not re-	34.011 G 111 (11 0 G	ndanying causa giv	en in Fait i.	10.0		Probably *XIDUnknown
970	requ	Completed						10.16		- AMOUNT
ec	law has b	ם						24a. Was a autops	y prior t	autopsy findings available o completion of cause of
=	The page	ပ်						perform		? es X2√X No
Vital Records,	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26, Place of Death	(Check only on	9/	
	Physi this c al dire	ျ	1 ☐ Yes XX No		ER/Outpatier	nt 3□ DOA Oth	er: 4 ☐ Nursing Hon	ne 5□Reside	nce 6 □Other (S _i	oecity)
Division of	ding P	Certification:	27. Manner of Death XX⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	w injury occurred	
Sio	tendi eath. tor: A	cat	2 Accident investigat 3 Suicide 6 Could not	ha	<u> </u>		Yes 2 □ No			
Ξ	or Ati	ŧ	4 Homicide determine		nome, farm, str ify)	eet, factory, office	2	28f. Location (St. City or Town	reet and Number or . r, State)	Rural Route Number,
Ω	To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		VV							
	Host 4 hor Fune ely fi	Ca	(Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	owledge, deatl ation and/or in	n occurred at the tir vestigation, in my o	me, date and place, a pinion, death occurre	and due to the ca	luse(s) and manner ate and place, and d	as stated. ue to the cause(s)
	the hin 2 the mplet	Medical	onej	and manner stated.						
	To To		29b. Signature and title of certifier	111-		29c. Licens	e number	25	d. Date signed (Mo	ntn. Day, Year)
			Moun	i sevicer	<i>y</i>	D56	691		June 18,	2006
	1		30. Name and address of person wh			·				
	1		Ghousia Sult	ana, 3227 Be	el Pre	Road, Si	lver Sprin	ng, MD	20906	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature A	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23a line b 27, pen/IL 8857 7/7/06 TT
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Ostorne (6 M 2006 20: JUNE Dorman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKING BAYVEN MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/01/1960 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 18 M 2□ F 216.78.1325 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Baltimore Dundalk Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 939 Oakleigh Beach Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Residential/Commercial 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Harrison Osborne Doreen Weaver P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Osborne Charlene/Sister 939 Oakleigh Beach Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🛎 Cremation 3 ☐ Removal from State Jun 16 20c. Location - City or Town, State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²Cremation sandariuneral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ocaine /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physicien Division of Vital Records, P.O. Box 68760 Physician/Medical his certificate has been signed by the attending physical director, page 2 should be deteched for use as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 No UnknownM death. LAKROWA Accident June 1,2006 6 CCOuld not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Unknown Un Known Westifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 JUNE 19,2006 MEDICAL DUCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MARYLAND MATTHEWBALDWIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 2005 Registrar

06-04225 Nathaniel Postell

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner NATHANIEL POSTELL 1010 hrs June 18, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 3670 Chesterfield Avenue **Baltimore City** N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8 irth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Director 266 58 9237 Months Davs Hours Min 1X M 2 Country) FLORIDA 65 Usual Residence of Decedent Iny 10a State 10b. Count 10c. City, Town or Location 1 X Yes 2 No 28a-f show or items 23a or 28a-f shov must be notified at once. imore, MD 21215-0036
Pages 1 and 2 should be filted within 72 hours after death with the Maryland neut of Health and Mental Hygiene. MD BALTIMORE N/A Director 10e. Street and Number 10g. Citizen of What Country? 3670 CHESTERFIELD AVE 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes "natural", or Yes 2 X No specify: Specify: BLACK Widowed If Yes, Give Year Divorced Examiner 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) Important: If item 27 is marked other than " injury or other traumatic event, the Medical 11TH PIPE LAYER C.J.LONGFELLOW 17. Father's Name (First, Middle, Last 18 Mother's Name (First_Middle_Maid illiam Be any 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) PAMELA POSTELL (WIFE) CHESTERFIELD AVE . BALTO, MD . 3670 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 1 Burial 2 Cremation 3 crematory or other place) Removal from State GARDENS OF FAITH JUNE 23,2006 BALTO, MD. onation 5 Other Specify chature of Funeral Service Licenses ALVIN B. SCRUGGS FUNERAL HOME I 1 4 1 2 F PRESTON ST BALTO MD death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21213 Approximate Interval 23a. Part I. Enter the disease, or complications that cause Physician failure. List only one cause on each line. 8 etween Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If ves. outcome of pregnancy Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed' death? Yes 2 **✓** Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene After this 1 V Yes ဥ 28a Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 V Natural 5 Pending Yes 2 No within 24 hours after death. To the Funeral Director: 24 hours after death. the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Hamicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 19, 2006 30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

			1 - For State Registrar	State of Ma	ryland / Depa	artment rtificate			ind M	lental F		ene . No. 2. 11	ns	101.70
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Ц	Funeral Director		5. Social Security Number 220-30-6540 6. Solution 1 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 89 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of (Month, July)	Birth Day, Y	1916	9. Birth Cou Mar	place (State or Foreign intry) 'y Land
	e Maryland 3a-f ehow	ctor	10a. State 10b. County Maryland N/A		10c. City, Town or Lo									10d. Inside City Limits 1
	th with th 23a or 21 1st be nu	Funeral Director	10e. Street and Number 2657 St. Benedic	Street		10f. Zip C	2122	23			10g	Citizen of U.S	What Cou	intry?
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Replacement

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,			M.W.An	_ MIS			038409		7/-	1/06	
			30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, I	Print)			- 41	-74	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 20, 2006 4:25A M ELAINE BOBBITT RICHARDSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 17 E. 21ST STREET BALTIMORE If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 9. Birthplace (State or recountry)

AUG. 13,1960 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1□M 2□F 45 215 70 6884 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itema 23a or 28a-f ahow 1∏Yes 2∏No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 E. 21ST STREET 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ia marked WOODROW BOBBITT, SR. MARY WORLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 f Health itam 27 BALTO, MD. 21218 20c. Location - City or Town, State HERBERT RICHARDSON(husband) 17 E.21ST. STREET Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Depertment of I Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) GARRISON FOREST JUNE 27,2006 OWINGSMILLS, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 3a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician NATURAL /Medical Due to (or as a consequence of) Examiner HIN /AIDS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ettending physicien end for use as the burial-transit SUBSTANCE Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown certificate has been signed rector, page 2 should be det Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Tes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner?

1 Pres 2 No Medical Certification; To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death 28b. Time of Intury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how intury occurred 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide ō within 24 hours e To the Funeral (completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year) 2006 D63686 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petros Karakousis, MD 600 N. WOLFE ST CARNEGIE 346 BALTIMORE, MD 21287 LJOHNS HOPPINS HOSPITAL-31. Date filed (Month Ray Year) 2006 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** June 18, Nicola E. Rossi 2006 9:40 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Harford Havre de Grace Citizens Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**∑**M 2□F Yrs. Jan. 28, 212-30-3295 86 1920 Italu Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a. State 10b. County in then "naturel", or iteme 23s or 28s-f show the Medical Examiner want by notified at 1 ☐ Yes 2 No Maryland Harford Abingdon Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Box Hill South Parkway, Apt. 227 21009 u.s.A. Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 Car Inspector of Health and Mental Hygie Heam 27 is marked other in other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Augustina Triviso Giovanni Rossi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Health ar Important: If Item 27 is eny injury or other trau Mr. Nicola Rossi 3714 Swift Run Court, Abingdon, MD (son) 20a. Method of Disposition

1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gardens of Faith Cem. 6/20/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death POWAMEMIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner now onsin fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last (or as P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of deaty?? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Medical Certification; To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 D No 24a. Was an 2 No 1 Yes 26. Plac of Death (Check only one) 25. Was case referred to medical examiner Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **3** No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manu r of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation the within 24 hours efter deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide o the Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Mo State Registrar

			For State Registrar	State of M	aryland	•	artment <i>rtificate</i>			Mental	Hygier	2 U L	16	19483
đ	Physicia	an	1. Decedent's Name (First, Middle, Las	RAUS	CH					2. Date of Month	1 1		ваг С С С	3. Time of Death 2:30 P M
,	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	, – , ,		4b. City, T	Γown, or I	Location of De		<u>_</u>	4c. County of	1	2:30 F
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. fnside City Limits
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	death with the Maryland ims 23s or 28s-f show r must be notified at	rai	1701 Parkvue Road						1047	10		U. S		
36	be filed within 72 hours after death with the Marylan de liydylene. de lydylene. de ther than "natural", or Itama 23a or 28a-f show avent, the Madical Exercitrar trust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,		Was Decede f Yes, speci 1 ☐ Yes 2	ify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes o erto Rican, etc	or No- :.)	14. Race - Black, Specify:	White, e	
aryland 21215-0036	2 hour		15. Decedent's Ed	ucation		16a. Dece	dent's Usual	l Occupa	tion	ndiss	16b	. Kind of Busin	ness/Ind	ustry
215	within 72 ene. then "na! ne Medic	Completed	(Specify only highest grad	College (1-4or	5+)	life.	DO NOT us	e retired)	uring most of w	rorking				
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and	ould be fi Mental H arked ot atic svar	o Be	Rosato Mastrac	ci						a Marie				
ary	S D E E	٩	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address	(Street a	nd Number or				ate, Zip (Code)
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ore	ges 1 av 1 of Hea If Item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	CE	lace of Dispo emetery, crer	natory or oti	e of her place		Date		Location - Ci		
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Ba	permit. Pages 1 Department of H Important: If Ite any injury or otl	2.0	21. Signature of Funeral Service Licen	1		A	ir In	.c.,	610 W.	Macpha	il Ro		Air	Of Be1 Md.21014
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each li	ine.		er the mode	of dying	, such as card	ac or respirate	ory arrest,		1	Approximate Interval Between Onset and Death
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/ita	ysician: The l is certificate he director, page	Be	25. Was case referred to medical examiner?	I I ia - I				104-	26. Place of E	eath (Check o	only one)			ASSIS HUE TIVING
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_	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certification to the funeral director, completely filled in by the funeral director.	Medical C		ysician: To the best iner: On the basis of and manner st	of examinat									
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	6		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	7 ,7	61.	7 AS A	2	- 12-	0 -	1226
	<i>Q</i> Sta	i la	31. Date filed (Month, Day, Year)	32. 32. 32. 32. 32.	KHUE rar's Signa	ture	0, 1.6	·15.	Dre,	(607)	DH LI	6, 111	U Z	127
i.	Regist	rar	30. Name and address of person who due Noy KLOESZ, 5 31. Date filed (Month, Day, Year) JUN 2 1 20	006	h.Rus de	K A	mark!	,						

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2006 1948

		For State	Cen	tificate of De	ath		Reg.	No.	10 1040
Physician/ ledical Examine	1.	Pecedent's Name (First, Middle, Last)	Stream	<u>ک</u> ا		Mo	nte of Death onth D ne 15, 200	ay Year 06	3. Time of Death 1550 hrs
EMC.	4:	a. Facility Name (if not institution, give str University Hospital STU	eet and number)		ty, Town, or Loca Itimore	ation of Death		4c County of Dea	ith
Funeral Director	3	Social Security Number 6. Sex 17-29-0209 1 XM sual Residence of Decedent	7. Age (In yrs. la			Under 24Hrs. 8. D Hours Min.	oate of Birth(I	-90 S	
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ith the Maryland 23a or 28a-f sho notified at once		0e. Street and Number 2242 South	HOTH ROC	id	2122	.0		USA	+
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5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam		15. Decedent's Education (Specify only h	ighest grade completed) College (1-4 or 5+)		working life. DO	NOT use retired)		6b. Kind of Busines	lent
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Dre, MD 21215-003 es 1 and 2 should be filed within the Health and Mental Hygiene. If item 27 is marked other it her traumatic event, the Med To Be Comm		9a. Informant's Name/Relationship (Type, Marikyn T. Chee	ZUM	2242	_Sove	Horni	101.M	1iddle7	te, Zip C@1/270
of H		20a, Method of Disposition 1	Removal from State	Place of Disposition crematory or other place.	ace)		1/06	Balk	·MD
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Physician /Medical		23a Part I. Enter the disease, or complicat failure. List only one cause on each I			ode of dying, such	h as cardiac or resp	ratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
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Division pital or Attent ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he (Specify) Local Street		ctory, office build		or Town, Sta		Rural Route Number, City dle River, MD
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T. W. T. O.	- ≩ 	29b. Signature and title of certifier	llan		29c. License nu O.C.M.E		1	29d. Date signed <i>(1</i> June 16 , 2006	Month, Day, Year)
5		30. Name and address of person who con Carol Allan, MD Assistant	npleted cause of death (Item Medical Examiner	123a) 111 Penn Stre	et, Baltimore	e, MD 21201			
Sta Registr		31. Date filed (Month, Day, Year)	32. Rogistrar's Signati	K Apach	8)				
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State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Abu Hassan Al Shariff 06/15/06 11:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lorien Frankford Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2 ☐ F Director 06/29/42 276-36-6912 63 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it if them 27 is marked other than "natural", or iteme 23a or 28a-f ehow ury or other traumatic event, it is Medical Exaction must be notified at ury or other traumatic event, it is Medical Exaction must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1√ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1020 Payson St. Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
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1 ♣ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 06/17/06 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee meda Jones 638 N. Gilmor St. Balto., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive pulmonary **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 - NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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06-04178 Craig Spencer

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First Middle.Last) 2. Date of Death Physician/ Month Craig Spencer 1743 hrs Medical Examiner June 16, 2006 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Baltimore City Johns Hopkins Hospital B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of If Under 1 Year If Under 24Hrs. 7 Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** x 44 Months Days Hours 220-81-1282 oreign **MD**untry) Director 09/27/1961 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a State MD Yes 2 No Baltimore City Baltimore or items 23a or 28a-f show must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> Director 10f Zip Code 10g. Citizen of What Country 10e. Street and Number 907 N. Luzerne Avenue 21205-USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Black Specify: Yes f Yes, Give Year 1 Yes 2 No specify: Divorced 3 Widowed ₽ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Itimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Betty Richey Be AME nomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Richey 907 N. Luzerne Avenue Baltimore, MD 21205-Date 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Jun 24 crematory or other place Burial 2 Cremation 3 Removal from State Gwynn Oak, Maryland WOODLAWN CEMETERY 2006 Donation 5 Other Specify nature of Funeral Service Licensee 22 Name and Address of Facility S JR FUNERAL SERVICE PA 1814 North Broadway Baltimore, Maryland 21213one art I. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. /Medical Death Narcotic and Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last iten#18,23a,27,28a-f,perME,g856,6/26/06 TT Physician/Medical UNPENDED AMENDED attending physician or use as the burial certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown q Unknown ned by the a detached fo signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 V Wknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? Yes 2 No 1 XX Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Inpatient 2 🗸 🙀/Outpatient 3 DOA Nursing Home 5 Residence 6 Other မှ 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Natural Yes 2 χ No 5 Pending Fnd 6/16/2006 unknown after death. 24 hours after death. Funeral Director: the unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 907 N. Luzerne Ave. Baltimore, MD filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined found in residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 17, 2006 eted cause of death (Item 23a) 30. Name and address of person who com-Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32 Registrar's Signature 31. Date filed (Month Day, Y20)06 State

Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 19487

		1- For State Registrar		Cei	rtificate	e of i	Death					Reg. No.	61	JU	0 1540
Physicia edical Exami	n/	1. Decedent's Name (First, Middle, Last) Keith Dennis Swope 2. Date of Death Month Day Year June 18, 2006												3. Time of Death 1420 hrs	
		4a. Facility Name (if not institution 2928 Yorkway	n, give street and nu	mber)	-	41	Dundal		ocation o	f Death			c. County o		nty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthda	ay)	If Under		If Under		8. Date of	Birth (MM	/DD/YYYY)	9. Birt Foreigi	hplace (State or
Director		219-84-8946	1 XM 2 F		44	Yrs.	Months	Days	nours	IVIII I.	May ´	0, 1	962		intry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or I	Locatio	n		-						10d Inside City Limits
Maryland 28a-f show i at once.	ō	4	imore		Dunda	alk									1 Yes 2 XNo
e Mary or 28a-	Director	10e. Street and Number 2928 Yorkway					10f. Zip C	^{ode} 1222)				izen of Wha	at Coun	try?
with the M ns 23a or 2 be notified		11. Marital Status		edent Ever in U	.S. 13		Decedent	of Hispa	anic Origi		cify Yes or		14. Race		can Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Montal Hygiene. Mari: If item 27 is marked other than "natural", or items 23a or 28a-f she mari: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 M 3 Widowed 4 Div	arried Armed For 1 Yes orced If Yes, Give Yea	2 X No			s, specify Yes $2X$			ruello Ki	ican, etc.)		White,		+0
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36 thin 72 ho te. than "na edical Ex	ompleted	Elementary/Secondary (0-12)	College (1	-4 or 5+)			st of worki		OO NOT I	use retired	a)			1	
215-0036 be filed within 7 ntal Hygiene. rked other than	Com	11 years 17. Father's Name (First, Middle	Last)		Ca	arpe	enter		Mother's	s Name (F	irst, Middl		Constr	ruct	ion
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other that it a Medic event, the Medic e	å	Daniel Sylveste		r.							e F.				
MD 21 td 2 should 1 tlth and Mer m 27 is mar	2	19a. Informant's Name/Relations Charlotte Shupe		her		-		,					ity or Town		Zip Code)
ore, MD 2 is: 1 and 2 shou of Health and N if item 27 is n		20a. Method of Disposition		20b.	Place of D crematory	isposit	ion (Name				Date 22,				Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		4 Donation 5 Other S	n 3 Removal fr pe <i>cify:</i>		ist Í			Cen	ne.		06	Du	ındalk	c, M	aryland
Balti permit. Departm Imports		2 Signature of Funeral Service	Licensee)	nolle	12	22 N	meii	y Fu	iner	al Ho	me O	Dur	ndalk, ndalk,	P.A	21222
Physician		23a. art I. Enter the dise se, or failure. List only one cause	complications that c	aused the death	Do not e	nter the	mode of	dying, st	uch as ca	ardiac or r	espiratory	arrest, sh	ock, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hyperter	sive athe		erot	ic car	diov	ascul	ar di	sease				Death
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8760, tificate be ng physic as the buri	n/Medical	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg		□ Fot	al death	3	Ectonic	pregnano		23	d. Date of o	,	ay Year
Box 687, he death certific	siciai	past 12 months?	4 Pregr	ant at time of de			er (S <i>pecif</i>		Lotopic	program	-9		Month		ay rear
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of Vital Recing Physician: The l	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outp	atient		10	ther ₄		Home 5	Reside	ence 6	Other	Scene
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Sior Attend r death ector: by the	icatic	2 Accident Inve	stigation 28e Plan	e of Injury - At h	nome, farm	. street	. factory.		es 2		8f. Locatio	n (Street	and Numbe	r or Ru	ral Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial—transi	Medical C		hysician: To the beaminer:On the basis	of examination											
E & E S	Me	29b. Signature and title of certifi		16				License				- 1		·	oth, Day, Year)
	3	30. Name and address of person	Y WI	sh of death (Ho	n 23al			O.C.M	1.⊏.			Jur	ne 19, 20	מטנ	
4	5 9	Jack Titus MD. De	outy Chief Medi	cal Examine	er 111		n Street	, Baltii	more, l	MD 212	01				
S Regis	tate	.111101.7 1	2006 32.	egistrar's Signat	ture A	dos	Ke .								
Negis	1121														

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>006</u> **Physician** April 29. 08:30 a M Hubert W. Sturm /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 5308 Barbara Avenue If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 € M 2 □ F Yrs. July 19, 1910 Director 213-01-2278 95 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1♥ Yes 2 No Baltimore Directi 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21206 5308 Barbara Avenue death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk filed within College (1-4or 5+) Elamentary/Secondary (0-12) 8 billing clerk marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any injury or other traumatic event, once. 17 Father's Name (First, Middle, Last) Be Hubert Jerome Sturm Elizabeth Johanna Stallo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary R. Denaro/daughter 5308 Barbara Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD uns Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) neunonia **Physician** /Medical Due to (or as a consequence of) Examiner Prostate CANCEL STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last use as the burial-P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2♥ No 24a. Was an autopsy performed? page 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\) Nursing Home 5 \(\)Residence 6 \(\)Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated. To the 29b. Signature and title a (Item 23a) (Type-Print) who completed cause of dead 80 MD 32. Registrar's Signature State 2006 Registrar

		-	For State	State of Maryla		artment of rtificate of			_ 4.00	6 19489
		٠	Registrar 1. Decedent's Name (First, Middle, Las	()		Tillicate of	Dealii	2. Date of Dea	Reg. No.	3. Time of Death
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less.	Examin	er				4b. Oky, rount,			,	
40			5. Social Security Number 6. Se	County General Ho	OSDI tal s. last birthday)	If Under 1 Yea		Columbia S. 8. Date of Birtl	h 9. B	Howard inhplace (State or Foreign
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	the 28a	Jec.	10e. Street and Number	ovuru		10f. Zip Code	Ellicott City		10g. Citizen of What (Country?
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פ	othy oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle,	Maiden Sumame)	
<u>a</u>	Aenta Aenta rked tice	To	Sylvester	Ellsworth Ault				Ida Cl	ifford VanBracl	de
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and page.	0 3	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Stree	et and Number or F	Rural Route Numbe	r, City or Town, State	. Zip Code)
Σ	alth a		Mrs. Marilyn Shipley	y Daughter		8101 Wood	ed Glen Ct. E		laryland 21043	
Baltimore,	item		20a. Method of Disposition		. Place of Dispersion of Dispe	osition (Name of matory or other p	lace)	Date	20c. Location - City of	or Town, State
Ę	Page ent c nt: If ry or		1 Surial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify			-		06/20/2006	Elkrida	e, Maryland
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ñ	Depa Impo any i		Ullmilk	MOLTON	11/22	Slack	Funeral Hor	ne, P.A.		
	244		23a. Part 1. Enter the disease, or communication cause (Final	elications that caused the de	ath. Do not en	ter the mode of d	ying, such as cardia	ac or respiratory ar	tt City, MD 210	Approximate Interval Between
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	attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of preg					23d. Date of d	elivery
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Sic	tend Jeath tor: the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Injuny . A	t home form s			28f Location (Street and Number or	Rural Route Number
Division	of or Attending Fafter death. I Director: After din by the funer.	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	areat, ractory, onic	•	City or To		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 - Certifying Ph	nysician: To the best of my	rnowledge de-	th non-read at the	time data and also	ce and due to the	calleg(e) and manner	as stated
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	\		Horder Her	Mille		D.	4 332	->	JUNE 1	6 2000
	10		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	Print) ABE	DA ALI	KHAR	nahin	101 2 1011
3			30. Name and address of person who JUN 2 1	32 Balistrar's Si	D /ft/K	DRY RI	ask Ko	ex, col	LINDIA 1	10 2/014
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State of Maryland / Department of Health and Mental Hygiene 2 0 6 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Vear **Physician** Stevenson 1852 trude /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 2 192 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 X F Months Days 83 216-18-0068 1923 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 **USA** 5302 Eastbury Avenue, Apt. C death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes. Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify þ 3 Widowed 4 Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Clerk Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lightry or other traumatic event, DRGs. Be Chase Emma Stewart Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Rosado - daughter 5403 Remmell Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory | 6/22/2006 Beltsville, MD 21. Signature of Funeral Service Licenses 22 CAFA and Stephen D. Lohrmann, PA Towson, 8717 Green Pastures Drive, M00986 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OVUNARI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the all d be detached for 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an page 2 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? uneral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After A hours after deau.

-rel Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of reson who completed cause of death (Item 23a) (Type, Print) 560 LOCH RING erald 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 _ For Stete Registrar	State of M	larylar				lealth a Death			iene 2	006	1949
	Discosia:		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		James Blaine Span	ks Jr.							06		2006	12:11a ^M
	Examir		4a. Facility Name (If not institution, give)				Location o	of Death			nty of Death	
			Suburban Hospital					Bethe				M	ontgor	nery
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent			Yrs.					07-12-	-1922	Del	Laware
	land W		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	MD Montgome	ery		Bethes	sda							1 ☐ Yes 21∑No
	7.28s	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Cour	ntry?
	3a o		5711 Cromwell Dr.					2	20816			USA		•
	deat	Funeral	11. Marital Status	12. Was Decedent		.S. 13. \	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ	
٥	or its		1 ☐ Never Married 2 ☑ Married	Armed Forces' 1 X Yes 2 ☐ If Yes, Give		NII I	r ves, speo 1 □ Yes		n, mexican Specify:	, Риело	Hican, etc.)		lack, White,	_{etc.} √hite
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ב	a within 72 hours after death with the Marylan Jiene. r then "netural", or iteme 23a or 28s-1 ehow the Mudical Examinar mari La notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Deced (Give	dent's Usua kind of wo	al Occupa nk done d	ation <i>furing</i> mosi i)	t of worki	ng	16b. Kind of	Business/In	dustry
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and 21215-0036	la pe	Be	James Blaine Spark	s Sr.							nn Smith		anne)	
>	nd 2 should tith and Ment 27 ie markae r traumatic	ပ	19a. Informant's Name/Relationship (Ty)			19b Mailin	na Address	(Street a			l Route Number		m State Zin	Codel
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ā,	of Health of Hem 27 i		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	2	D	ate	20c. Location	n - City or To	own, State
Ê	Page ent o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		emetery, cren esapeak				06-	20-2006	Bel	tsvill	e, MD
saltimore,	permit. Pages 1 Department of H Important: if Ite eny injury or ot once.		21. Signature of Funeral Service Ligence	98	10038	32 22	. Name an	d.Addres	s of Facilit	× a	emation	a .		
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П			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause	d the deat	h. Do not ente								Approximate Interval Between
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	י ק	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		,				,				
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7	uires that the de. signed by the e Id be detached f	Q.	Part II. Other significant conditions con	tributing to death t	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use co	ntribute to th	ne cause of death?
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ecol	> 0 %	lete									24a. Was ar	n 24h	Were auto	nev findinge available
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VII	iclan: Th certificete ector, pag	ပ	25. Was case referred to medical			-			26 Place	of Death	1 Yes 2	No	1 🗆 Yes	2/2 No
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ו סו	ding Phys h. After this funeral di	ı.	27. Manner of Death	28a. Date of Inju (Month, Da	ury	28b. Time of Injury		Bc. Injury Work			8d. Describe ho			,
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<u> </u>	I or Atten after deat Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At ho	ome, farm, stre	eet, factory	, office	100-0	2	28f. Location (Str City or Town	reet and Nurr . State)	nber or Rura	l Route Number,
2	spital or Atten ours after deat nerel Director: filled in by the	O												
	To the Hospital of within 24 hours all To the Funerel D completely filled it	edical	29a. Certifier 4 Certifying Phys	ier: On the basis of	of examinat	wledge, death tion and/or inv	occurred a	at the time	e, date and	place, a	and due to the ca	use(s) and m	nanner as st	ated.
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner st	tated.			. License						
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ħ	10%		30. Name and address of person who co	mpleted cause of c	Death (Item	1 23a) (Type, I		FIT	1 1	2F7	THESD	A. A	11	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	J 0/	(11)	<u>,, , , , , , , , , , , , , , , , , , ,</u>	ا بر	11100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Registr		JUN Z I	LUUD JA	Messer	15.	6000	وع						

Physician		For State Registrer 1. Decedent's Name (First, Middle, Last	State of Maryla			ate of		2. Date of D	Reg. No	200		Time of Death
Physiciar /Medica Examine	1	4a. Facility Name (If not institution, give	phenson Spital		4b. Ci	ty, Town, o	r Location of Dea	6	40	200 County of E	6 eath	3:10pi
uneral rector		5. Social Security Number 6. Se		rs. last birthday) Yrs.	If Und Month	der 1 Year s Days	If Under 24 Hr Hours Mir		rth	9.	Birthplace	(State or Foreigngton DC
Ba-f ehow	Ulrector	10a. State 10b. County MD Montgot	1	Potoma	С							Inside City Limit 1 H Yes 2 □ N
23a or 2		100. Street and Number 10130 Falls Rd.			10f. 2	Zip Code	20854		10g. Cit	izen of What USA	Country?	
"natural", or fleme 23a or 28a-f ehow idical Examiner must be notified at lated by Eumaral Director	2	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates:			cedent of Hoecify Cuba 2 X No	ispanic Origin? (In, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - A Black, W Specify:	merican I /hite, etc. Whit	
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			kind of t DO NOT	work done o use retired	ation during most of we hologist			ind of Busine		
5 6	0	17. Father's Name (First, Middle, Last) Raymond Leslie Hi	:	02211		20,0	18. Mother's Na	ame (First, Middle ys Raine	, Maiden	Sumame)		
r traum		19a. Informant's Name/Relationship (Ty Randolph Robert S		196. Mailis sband	ng Addre	ss (Street a	and Number or R alls Rd.	Rural Route Numb • Potoma	e <i>r, Cit</i> y o	r Town, Stat 20854	e, Zip Coo	de)
any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei hesapeal	natory o ke C	rother plac remat	ory 06-	Date -21-2006	Ве	eltsvi		
eny in		21. Signature of Funeral Service Licens	Z MG1358	22	Rap 933	and Addres p Fun Gist	eral & (Cremation Lver Spr	n Sei	rvice	10	
e burial-transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	3× ea	-st (ĉen cer				On	set and Death
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, e	2	Part II. Other significant conditions cor	tributing to death but not r	esulting in the u	nderlying	cause give	en in Part I.					use of death?
page 2										prior t death	o comple	indings available tion of cause of No
I director, pag	ם	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 🗆 [Othe Othe		eath <i>Check only</i> of Home 5 ☐ Resi		S Other /S	nacifu)	
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stely filled in by the		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)				28f. Location (City or To	wn, State,)		
Medical	edica	29a. Certifier (Check only one) 1. Certifying Physical Certifying Physical Examination (Check only one)	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurre estigatio	or at the time on, in my op	e, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner place, and d	as stated ue to the	cause(s)
шоо	Σ	29b. Signature and title of certifier H. Aft	MD		2	9c. License	number \$2167			signed (Mo		Year)
		30. Name and address of person who co Hussein Akhondi 8	mpleted cause of death (It 600 Old Geor	em 23a) (Type,	Print) Rd.	Bethe	sda, MD	20814				
State	e	31. Date filed (Month, Day, Year) JUN 2 1 200		nature	sele.	·						

DHMH 17 Rev 1/2001

Stephenson, Sally H VU-1910 3:10 pm (1)

			1 - For State Registrar	State of Marylar	nd / Depa		Health and		/giene 006	19493
	Physici	an	Decedent's Name (First, Middle, L	Lucille		Sherow		2. Date of D Month	Day Year	3. Time of Death 6:30 A M
	/Medio		4a. Facility Name (If not institution, g				or Location of Dea		18,2006 4c. County of Deat	
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	Funeral	947		Sex 7. Age (In yrs.		If Under 1 Year		s. 8. Date of B		hplace (State or Foreign
*	Director		217-48-4787	1□M 2X0F 89	Yrs.	Months Days	Hours Mil			irginia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tor	Maryland Bal	timore			D1 77			1 ☐ Yes 2½ No
	r 28a	by Funeral Director	10e. Street and Number	CIMOLE		10f. Zip Code	Fort H	oward	10g. Citizen of What Co	untry?
	th wit	alD	7606 Chestnut	Ave.			2105	2	United Sta	ates
	ar dea	Iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? I	(Specify Yes or Nerto Rican, etc.)	o- 14. Race - Ame Black, Whit	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	<u> </u>	1 ☐ Yes 2 🛛 No			Specify:	
8	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28a-f show the Madical Exeminar must be notified at	ted t	15. Decedent's	Education	16a. Dece	dent's Usual Occur	pation		16b. Kind of Business/	White
212	hin 72 In "na Madi	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w	rorking		modelity
2	ad wit	Con	8 Years		Н	ousewife			Own Ho	me
n D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	ame (First, Middle	a, Maiden Sumame)	
Z	Men narke	ဥ	John Ewing	T. 01.1				ce Alfre		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hames 21 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinational be notified at another.	1 8	19a. Informant's Name/Relationship Marianne Dodge	(Niece)		ng Address <i>(Street</i> Ch estnu t			per, City or Town, State, 2 rd, Maryland	
ē,	Heall Heall tam 2		20a. Method of Disposition	20b. I		osition (Name of matory or other place		Date	20c. Location - City or	
altimore,	ages ent of nt: ff li		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	HUBINOAN HOIN STATE		natory or other place.		/21 /2006		
a E	mit. Partmoortar		21. Signature of Funeral Service Lice		22	Name and Addre	iss of Facility			
m	Depa Impo any is	. 0	Heath	(au)	79	ida-Ruck 22 Wise .	Funeral Ave. Du	Home of indalk. N	Dundalk, In Maryland 21	222
r S	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. ATRIAL	th. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
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O. Box	at the death certifical by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl déath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death ition and/or inv	estigation, in my o	pinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To son	2	29b. Signature and title of certifier	1.5. 11		29c. Licens			29d. Date signed (Month	
	, ,	}	30. Name and address of person who	1 Tulk	232\ /T	DZ Print)	1188		6-20-0 belle MD	26
	H		Sovindo y 1	July 2	-Ma	0100-	Plan	Dun	belle MA	21227
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	30				
1.4	Registr	ar	JUN 2 1 2	MAGNES .	No the	Bell !				

06-04183 Crystal Maria Stefanis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tifica	te of	Death				R	Reg. No	6	UU	b	1945
Physici edical Exam		Decedent's Name (First, Midd	Cryst	al Maria	St	efa	nis				Date of Dea Month June 16,	ath Day	Yea		3. Time of 1917	
		4a. Facility Name (if not institution 64 Willow Spring Roam)		umber)		41	b. City, Town Dundalk	, or Loc	cation o	f Death			County o			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birtho	lay)	If Under 1		If Unde		8. Date of Bi	rth(MM/D	D/YYYY			ate or
Director		213-72-0619	1 M 2 X F	48		Yrs.	Months [Days	Hours	Min.	Nov.	16,19	957	Foreig Cou	n ^{untry)} Mai	ryland
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n with the Maryland ms 23a or 28a-f sho be notified at once.		64 Willow Spi							1222				ted ;	Stat	es	
more, MD 21215-0036 Pages and 2 should be filed within 72 hours after death with the Maryland to fell and Mental Hygiene that is an and Mental Hygiene that "natural", or items 23a or 28a-f she in if item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 M	arried Armed F		S. 1		Decedent of s, specify Cul)- 1	 Race White 		an Indian,	Black,
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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 Burial 2XX Cremation	n 3 Removal f	om State	rematory	or othe	er place)									
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, h		30. Name and address of person	who completed caus	se of death (Item :	23a)									-		
10			sistant Medical I			nn Str	eet, Baltin	nore,	MD 2	1201						
St Regist	ate trar	31. Date filed (Month, Day, Year)	0000	gistrar's Signatur	e	100 A	200									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State Registra Amend Item #4c Per Phy C856 Costificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MINETTA SHREVE UNE 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number);
80N SECOURS Hoopite 4b. City, Town, or Location of Death **Examiner** BALTI MORE STREET 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 214-18-0631 1 □ M 2 2 F <u>Maryla</u>nd Director June 13,1922 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. Counts 10c. City, Town or Location 28a-1 shov other traumatic evant, the Medical Exeminer must be notified at Baltimore 1X Yes 2 □ No N/AMaryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 3310 Benson Ave., Apt. G25 USA 21227 Itams 23a Be Completed by Funeral death 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GC Murphy Co. Cash Office 0 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Maxwell Anna Slemaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sinent of Health an 21227 2708 Norfen Rd., Baltimore, Md. (Son) Edward Shreve, III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department Important: If any injury or 6/22/06 Baltimore, Maryland Loudon Park Cem. ' 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): **Examiner** small Bowel oBstruction. Dongs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner VENTRAL HERNIA RECURTENT burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown þ ۵. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ LETT 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has 2 No OBESITY 1 ☐ Yes of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 135 H 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Alter ! Certification: Division 1 Natural 5 Pending 1 Tes 2 🗌 No death. investigation 2 Accident Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined after 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00240 28 06/17/06 Bon SEcours Hospital, 2000 Bartimore St. Balt. mp 2/223

DHMH 17 Rev 1/2001

Registrar

EDUMEDO 31. Date filed (Month, Day, Year)

JUN 2 1 2006

32. Registrar's Signature

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19 Day **SWEREN Physician** JUNE 2006 9:59A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 02/11/1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🕠 F MD 90 212-09-8263 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene.
item 27 ie marked other then "nature!', or iteme 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be nutitled at or iteme 23a or 28a-f ehow 1 ☐ Yes 2 ¥ No Completed by Funeral Director BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 U.S.A. 11 POMONA SOUTH APT. #6 Pages 1 end 2 should be filed within 72 hours after death ¹ nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTIMORE **CLERK** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (LIPPMAN BRILL MINNIE SAMUEL FRANK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 POMONA SOUTH APT. #6 - PIKESVILLE, MD 21208 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s
Department of Health ar
Important: if item 27 ie
any injury or other trau BARBARA GOODMAN/DAUGHTER 20b. Place of Disposition (Name of MIKRO PROBLESH or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 06/20/2006 BALTIMORE, MD BETH ISRAFL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final lunu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to greath but not resulting in the underlying cause given in Part I. Part II. Dther significant conditions 3 ☐ Probably 4 → Onknown 1 ☐ Yes 2 🗆 No page 2 should Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 0 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier VUI) ed cause of death (Item 23a) (Type, Print) 838 Greene Tree Rd 21208 30. Name and address of person who comple 5 len JU emun 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

06-04146 Georgina Tabor

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 14, 2006 Year 1418 hrs Medical Examiner Rodriguez Georgina 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Harford BelAir Upper Chesapeake Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Country) 2_**X**F 08/27/1921 Peru 213-05-3525 1 M Yrs 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Yes 2 X No 28a-f show Harford MD Joppa with the Maryland Director 10g Citizen of What Country 10e. Street and Number 10f. Zip Code 21085 1520 Philadelphia Road USA items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Race - American Indian, Black 11. Marital Status Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes ō 1 Yes 2 X No specify White Specify: If Yes, Give Year 3 X Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Itimore, MD 21215-0036

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triment of Health and Mental Hygiene
ortant: I frieum 27 is marked other than "ms
ory or other tranmarite event, the Medical Ex-Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Jose Eduardo Rodriguez <u>Antonia Ramirez</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9326 Owings Choice Court, Owings Mills, MD 21117
of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Christina <u>Bregenzer</u> Niece 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o 6/16/06 Hampstead, MD Carroll Cremation Donation 5 Other Specify: 22 Name and Address of Facility 21. Signature of Funeral Service License 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home The dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Retween Onset and e cause on each line. failure. List only /Medical Death Complications of hypertensive atherosclerotic cardiovascular disca Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed ဒ XUNPENDED AMENDED attending physician or use as the burial item#23a,PII,27,perME,g857,7/31/06 TT ician/Medi Division of Vital Records, P.O. Box 68760, 12 Hospital or Attending Physician: The law requires that the death certificate be F. Hourus after death.

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F. Hourus after diversor: After this certificate has been signed by the attending physic etely filled in by the funeral director, page 2 should be detached for use as the buril 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Dementia Completed 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town. State) determined To the Funeral Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier O.C.M.E. June 16, 2006 ame and address of person who complete cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

2006

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			1 = For State Registrar	State of	Marylan	-	artmen rtificat				lental Hy	giene	006	19498
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S.	/Media		Steven A. Tipto								06	16	2006	12:11a ^M
7	Examir	ier	4a. Facility Name (If not institution, gi		per)		1		Location of	of Death			County of Deat	
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	Funeral Director		5. Social Security Number 6. 212-90-4144	Sex 7. 12X M 2 ☐ F	Age (In yrs.)	ast birtnday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day	h v, Year)		hplace (State or Foreign
			Usual Residence of Decedent								01-20-	-19/4	Ne	w Jersey
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip	Code		-		10g. Citize	en of What Co	untry?
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ylaı		ToE	Mark Wayne Tipto								Lynn Ja			
Mar	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship Patricia Helterb		nd						ers, MD			(ip Code)
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cau one cause on eac	sed the death th line.	. Do not ent	er the mode	e of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between
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687	ificate g phy: as the	8		0										
O.	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ∏ Fetal It at time of de	death 3	Ectopic pre Other (spe					23	d. Date of deli Month	very Day Year
α,	ires that the signed by th I be detache	by Pł	Part II. Other significant conditions	contributing to deat	th but not resu	iting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ord	w requires been sign should be	pieted									1 🗆 Y	es 2,12	Ńo 3∐Pro	babiy 4 Unknown
	The law ate has b page 2 s	Comple									24a. Was a autops perform	SV	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				O+-			(Check only or			
of	Phys this al dii	<u>۲.</u>	1 Yes 2 No 27. Manper of Death	28a. Date of I		PVOutpatien 28b. Time of			4 🗀 1401		ne 5 🗌 Reside			ify)
O	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	M	Bc. Injury Work¹ 1 □ Y	ai es 2 □ N	- 1	.od. Describe no	ow injusy o	xcurred	
Division	or Attending after death. Director: After in by the fune	fica	3 □ Suicide 6 □ Could not b	28e. Place of	Injury - At hor	me, farm, stre					8f. Location (S	treet and I	Number or Rui	ral Route Number.
ă	el or safter	Certification;	4 Homicide determined	building,	, etc. (Specify)					City or Tow	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one)	nysician: To the be miner: On the basi and manner	s of examinati	vledge, death ion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the ca	ause(s) ar ate and pl	nd manner as lace, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature add title of certifier	h			29c.	License	number		2	9d. Date :	signed (Month	Day, Year)
	\		1 Steph	SKA	29			D5	85/0)		06	116/	06
10	XX			completed cause	of death (Item	mc.	2001	Med	ical	Parl	way Anı	napo1	is MD	21401
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	2006 32. 199	istrar's Signat	& A	sele	9						
		-												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (19499 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1:45AM June 2006 Helen Tyransky 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 5031 Wright Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Jan. 1, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 □ M 2 🂢 F Months Hours Min. Pennsylvania Jan. Yrs. 83 198-18-1332 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Maruland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21205 u. S. A. 5031 Wright Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Warren Charles Dubroka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Tyransky (Spouse) 5031 Wright Avenue, Baltimore, Maryland 212<u>05</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Bayview Crematory 6/17/2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213 anes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final d Any unsala ne disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical **Examiner**

ŏ permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

Itam 27 is marked other then "natural", or Itama 23a or 28a-1 show other traumatic event, the Modical Exertiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Heatth and Mental Hygiene. ant: If itam 27 is markad other than

Funeral Director

Completed by

Be

2

signed b within 24 hours arter use..... To the Funeral Director: Aft

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

O Tallalla Para a sandblass	DRMENTIN			- Mear
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicess of Injury	Due to (or as a consequence of):			
that initiated events resulting in death) Last	c. Due to (or as a consequence of):			==
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		Date of delivery Month Day Year
Part II. Other significant conditions DIGSE LOS	contributing to death but not resulting in the unit		23e. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
	J		24a. Was an autopsy performed? 1 Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2N No
25. Was case referred to medical		26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing I	Home 5 X Residence 6 □0	Other (Specily)
27. Manner of Dath 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year) On 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Sescribe how injury occ	curred
3 Suicide 6 Could not determine		et, factory, office	28f. Location (Street and Nu City or Town, State)	mber or Rural Route Number,
	Physician: To the best of my knowledge, death aminer: On the basis of examination and/or invented and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. Date sig	ned (Month, Day, Year)
· M. M	Tobreson	D4575	7 June	19,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCNESSEY

32 Registrar's Signature

Matthews

31. Date filed (Month, Day, Year)

D45757 June 19, 2006

A. e Boetrone MD 21224

State Registrar

			State of Marylar State of Marylar 1 - State Registramend Item #2 Per Phy G856	nd / Dep	artment of H	lealth and I	Mental Hyg		06	1950) ()	
3 83	Physici	20	1. Decedent's Name (First, Middle, East)	, 0, =,	700 011		2. Date of Dea Month	Day	Year_	3. Time of De		
1	/Medic		CLARENCE EARL UTTER		l o		June	16,	2006	21:32	М	
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death	1	4c. Count				
4			Montgomery General 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday	Olney // If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	gomer		~oreian	
- <u>&</u> □ D	Funeral Director		364-30-3591 1 x M 2 F 92 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day	, Year) 3, 1913	Cour Can	lace (State or F try) ada		
yland	MON			ty, Town or L	_ocation				1	0d. Inside City I	Limits	
Man	Ties of	tor	MD Montgomery Si	llver	Spring					1 ☐ Yes 🕺	X No	
with the	3a or 28 at be no	i Director	10e. Street and Number 14601 Sturtevant Road		10f. Zip Code 20905			10g. Citizen of U.S.A		try?		
d 21215-0036 filed within 72 hours after death with the Maryland	and Menial Hygerie. Is marked other than "natural", or liems 23a or 28a-1 ahow aumatic event, Ira Madical Examinat must be multifist at	by Funeral	11. Marital Status 1 □ Never Married 2XXMarried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 XXNo If Yes, Give Year or Dates:	.S. 13.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bla Specii	ce - Americ ack, White, fy: Whi	etc.		
Maryland 21215-0036 d 2 should be filed within 72 hours aft	n "natur Magical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	durina most of wor	king	16b. Kind of B	Business/Inc	dustry		
27	renthing.	Con	Grade 12	Bu	ilding En			Engi				
D #	d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumai	me)			
Vald I	Men	2	Frank Utter				e (unknot					
Mar and 2 sh	t of Health and Men If item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Type, Print) Joan Marie Utter / wife		ling Address (Street Sturteve		silver			Code) 20905		
altimore,	Department of Health a Important: If Item 27 is any injury or other tra		1 Burial 2 KDCremation 3 Removal from State	cemetery, cre	position (Name of ematory or other place ndel Cremi		Date 20/2006	20c. Location Odent		_{wn, State} aryland	i	
Balti permit.	Departr importa any inju once.		21. Signature of Funeral Service Licensee / M007	770	Name and Addre Donaldson 313 Talbo	ss of Facility Funeral tt Avenue	Home, P	.A. l, Mary	land	20707		
	ysician Jedical		23a. Part 1. Enter the disease, or complications that ceused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Lower Gast resulting in death)	roint			or respiratory ar	rest,		Approximate Interval Betwe Onset and Dec 30 Hou	ath	
	aminer		Due to (or as a consect Diverticul		sease					30 Hou	ırs	
760, te be executed	ysician and Kie burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the									
O. BOX 68 the death certifical	attending phy for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feter 4 □ Pregnant at time of constitutions of the pregnant of the pregnant at time of constitutions of the pregnant at time of t	al death 3	□Ectopic pregnancy	,			ate of delive	ny Day Yea	ar	
rdS, P	been signed by the should be detached	d by Pi	Part II. Other significant conditions contributing to death but not res Acute Myocardial Infarction	ulting in the	underlying cause giv	ren in Part I.		obacco use con ′es 2 ⊠No		e cause of dea ably 4 🗀Unl		
Heco	10 01	Completed by					24a. Was autop perfor 1 🗆 Yes	SV	Were auto prior to co death? 1 \(\subseteq \text{Yes} \)	psy findings avanteller	allable ise of	
<u>a</u> ::	tifica tor, p	0	25. Was case referred to medical			26. Place of Dea	ath (Check only of		1 1 1 42	21/10		
DIVISION OF VITAL RECORDS, P.	ith. :: After this certificate had e funeral director, page 2	ation: To B	examiner? 1									
DIVIS	s affer des i Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, s	street, factory, office		28f. Location (S City or Tow		ber or Rura	l Route Numbe	∋Γ,	
1e Hospit	within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1XXCertifying Physicien: To the best of my known one) 1XXCertifying Physicien: To the best of my known one one of the best of my known one one of the best of my known one of the best of the best of my known one of the best o	owledge, dea ation and/or i	ath occurred at the til investigation, in my o	me, date and place opinion, death occu	e, and due to the d irred at the time, d	cause(s) and m date and place,	nanner as s , and due to	ated. the cause(s)		
Tott	To the comp	¥	29b. Signature and title of certifier Find J. My. mp		29c. Licens	e number 3630		29d. Date signe Jun	ed (Month, ie 19,			
	13		30. Name and address of person who completed cause of death (item Frank J. Mayo, M.D. 11220 Free			13 Gaith	nersburg	, MD 2	.0877			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 1 2005 32. Registrar's Signary	ature	A							